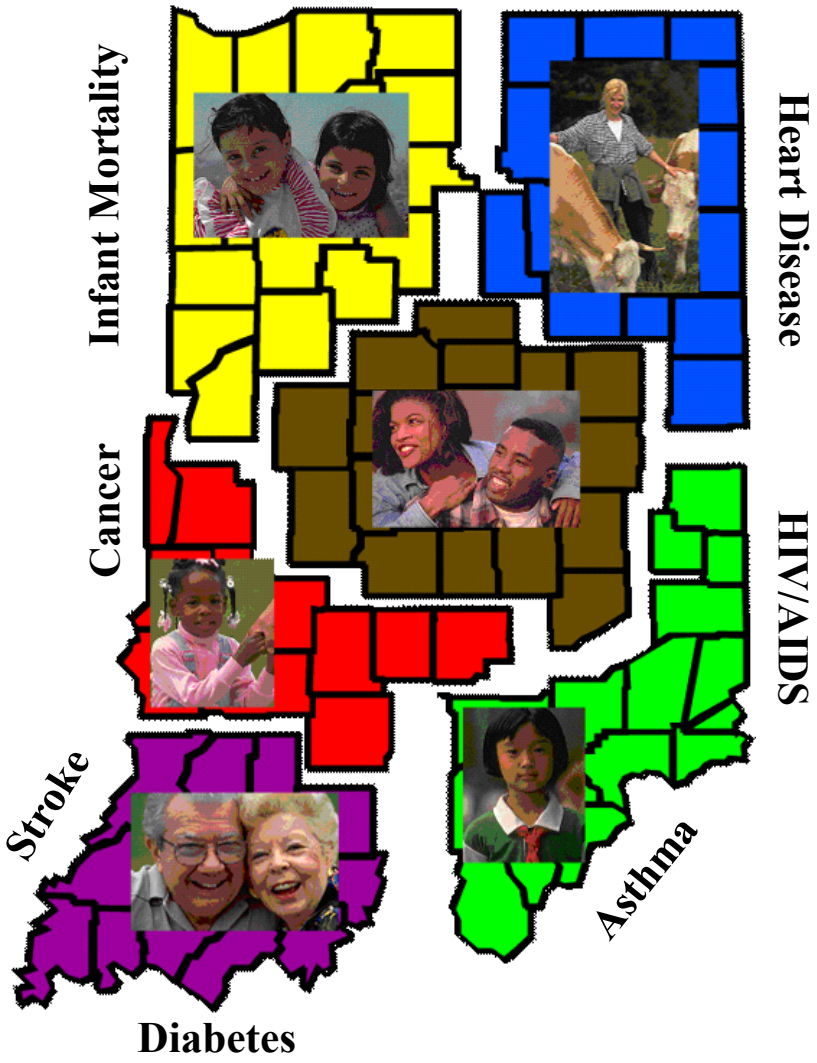
HEALTHY INDIANA – A MINORITY HEALTH PLAN FOR THE STATE OF INDIANA

HEAL the Gap

Health **E**quality



Access **L**eadership

MINORITY HEALTH ADVISORY COMMITTEE
INDIANA STATE DEPARTMENT OF HEALTH

Hoosiers working together to HEAL the GAP in racial and ethnic health disparities

PREFACE

We are proud to present the Healthy Indiana - Minority Health Plan for the State of Indiana. This is another significant step forward in addressing the health disparities of minorities in our state. In March 2002, the Institute of Medicine (IOM) released a report with startling revelations about health care delivery for minorities. The report was titled "Unequal Treatment: What Healthcare Providers Need to Know About Racial and Ethnic Disparities in Healthcare." Not surprisingly, the IOM found that the vast majority of studies indicted that minorities are less likely than whites to receive needed services, including clinically necessary procedures. These disparities existed in a number of disease areas, including cancer, cardiovascular disease, HIV/AIDS, diabetes, and mental illness, and are found across a range of procedures, including routine treatments for common health problems. Mortality for many chronic diseases is 1.5 to 2.5 times higher for minorities.

Indiana has long been a leader in developing systems to confront minority health disparities. The Indiana Black Legislative Caucus has played a pivotal role for several decades in bringing minority health issues to the forefront. In 1986, a Black and Minority Health Advisory Committee was created to advise Indiana State Health Commissioner, Woodrow Myers, M.D. The Interagency Council on Black and Minority Health was also created. Five counties began to form coalitions to address minority health issues in 1987, and the Indiana Minority Health Coalition was incorporated in 1994. This program has flourished and there are now 19 community coalitions throughout Indiana that address the health needs of all minorities. This system of minority health coalitions, which is unique in the nation, has been an extremely valuable component in confronting these disparities.

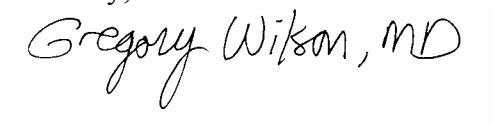
The Indiana State Department of Health has also been active in the area of minority health disparities with programs that include the Office of Minority Health, the Office of Cultural Diversity and Enrichment, a diabetes program for minority clients, prenatal education programs, HIV screening programs, a chronic disease management program that the State Department of Health and the Office of Medicaid and Policy Planning are developing as a cooperative venture, and multiple other endeavors.

During the last decade, Indiana has become much more of a multi-cultural state, and the challenges in meeting the health requirements of all Hoosiers have increased. To more fully define and understand the needs of minorities in our state, a Minority Health Report was produced by the Indiana State Department of Health Minority Health Advisory Committee in 2001. The report provided valuable data and direction for development of this new State Minority Health Plan. This plan is the result of intensive efforts by Indiana State Department of Health staff and multiple community partners and agencies that are members of the Minority Health Advisory Committee. These goals and objectives are closely aligned with the Healthy People 2010 priorities, but also recognize the specific needs and resources of our state. This document will serve as a framework for discussion, planning, and implementation of new health programs and will make a significant contribution to the overall efforts of our state to eliminate

minority health disparities. The plan can serve as an initial roadmap, but now we must decide where we need to go first, how we can get there, and what resources are available to make this journey possible.

We are deeply indebted to Dr. Edwin Marshall and to the entire Minority Health Advisory Committee for their efforts in developing this plan.

Sincerely,



GREGORY A. WILSON, M.D.
STATE HEALTH COMMISSIONER

INDIANA MINORITY HEALTH ADVISORY COMMITTEE MEMBERS
(All Invited Appointees)

CHAIR

Edwin C. Marshall, O.D., M.S., M.P.H.*
Professor and Associate Dean
School of Optometry
Indiana University

ISDH STAFF

Danielle L. Patterson
Director
Office of Minority Health

Antoniette M. Holt, M.P.H, B.S.P.H.
Epidemiology Resource Center

JoeAnn Gupton
Office of Minority Health

MEMBERS

Sung Boon Baik, M.S.W.*
Executive Director
Asian Help Services

Haywood Brown, M.D.*
Director
OB/GYN Residency Program
St. Vincent Hospital (Indianapolis)

Arturo Bustamante
Executive Director
Hispanic Center

Melvin Clark*
Past Vice President
Methodist Hospital (Gary)

Amos E. Cooley
Chairman of the Board
Indiana Minority Health Coalition

Stephanie DeKemper*
Executive Director
Indiana Minority Health Coalition

Brett Dennis, R.N., B.S.N*
American Indian Health Program
American Indian Center of Indiana

Carl Ellison*
Vice President, Community Affairs
Memorial Hospital (South Bend)

Anita Gaillard, M.S.P.H.*
Smoke Stoppers Instructor
St. Francis Hospital (Indianapolis)

Willie A. Gholston II, M.P.H.
Indiana Family Health Council

Lynne Griffith, B.S.W.*
Regional Program Director
Metro Indianapolis
American Heart Association

Susan Haber, J.D.*
Executive Director
The Hispanic Center

Kenneth Hornbuckle, D.V.M., M.P.H., Ph.D.*
Lilly Corporate Center

Kraig Kinchen, M.D.
Physician

Rhonda Lee*
Minority Health Coordinator
LaPorte County Minority Health Coalition

Aida McCammon, M.S.W., A.C.S.W.*
Executive Director
Indiana Latino Institute

Vernell Miller*
Director, Family Planning
Indiana Family Health Council

Barbara L. Murphy
Manager
Special Populations, Health Services
Office of Minority Health (South Bend)

Lori Peterson
Minority Programs Director
Indiana Tobacco Use Prevention and Cessation Agency

Raymond Pierce, M.D.*
Chair
Interagency Council on Black and Minority Health

Lillian Stokes, M.S.
Director of Diversity and Enrichment
School of Nursing
Indiana University

Garrett Uyeno, R.N.*
Intensive Care Unit
Winona Hospital

Gloria Webster-French, R.N., M.S.N.*
Director
Office of Cultural Diversity and Enrichment
Indiana State Department of Health

David Wilkes, M.D.*
Pulmonary Medicine
Indiana University Medical Center

Beryle Williams, B.S.W., M.S.*
Marketing Director
Health Care Excel

*Charter appointees to the Minority Health Advisory Committee

HEALTHY INDIANA MINORITY HEALTH PLAN WORKING GROUP

CHAIR

Edwin C. Marshall, O.D., M.S., M.P.H.*
Professor and Associate Dean
School of Optometry
Indiana University

ISDH STAFF

Danielle L. Patterson
Director
Office of Minority Health

Antoniette M. Holt, M.P.H, B.S.P.H.
Epidemiology Resource Center

JoeAnn Gupton
Office of Minority Health

MEMBERS

Dewana Allen
Intern
Office of Cultural Diversity
Indiana State Department of Health

Amos E. Cooley
Chairman of the Board
Indiana Minority Health Coalition

Brett Dennis, R.N., B.S.N.
American Indian Health Program
American Indian Center of Indiana

Willie A. Gholston II, M.P.H.
Indiana Family Health Council

Kraig Kinchen, M.D.
Physician

Aida McCammon, M.S.W., A.C.S.W.
Executive Director
Indiana Latino Institute

Shanna Murray
Intern
Office of Cultural Diversity
Indiana State Department of Health

Lori Peterson
Minority Programs Director
Indiana Tobacco Use Prevention and Cessation Agency

Raymond Pierce, M.D.
Chair
Interagency Council on Black and Minority Health

Beryle Williams, B.S.W., M.S.
Marketing Director
Health Care Excel

HEALTHY INDIANA MINORITY HEALTH PLAN REVIEW GROUP

EXTERNAL MEMBERS

Jessica Robinson Brown
Gary Community Health Center

Virginia Caine, M.D.
Director
Marion County Health Department

Brian J. Fahey
Citizen Appointee
Governor's Native American Council

Stephen Jay, M.D.
Chair
Department of Public Health
School of Medicine
Indiana University

Nancy Jewell, M.P.A.
Research Consultant
Indiana Minority Health Coalition

Shelvy Kegler, Ph.D.
Chair

Jerry King
Executive Director
Indiana Public Health Association

Amelia Muñoz
Program Director
Indiana Latino Institute

Maria Quiroz-Southwood
Interim Director
Wishard Hispanic Health Project

Kathleen Russell, D.N.S, R.N.
School of Nursing
Indiana University

Olga Villa-Parra
Evaluation Consultant
Olga Villa Parra & Associates, Inc.

Angie Tyler
HealthNet, Inc.
Interagency Council on Black
and Minority Health

INTERNAL MEMBERS

Joyce Black, M.S., R.D., C.D
Program Manager, Indiana Diabetes
Prevention and Control Program
Indiana State Department of Health

Michael Butler
Director of the Division of HIV/STD
Indiana State Department of Health

Sue Percifield, R.N., M.S.N.
Director of the Division of Chronic and
Communicable Diseases
Indiana State Department of Health

Michael Wade
Program Manager, Indiana Cancer
Consortium
Indiana State Department of Health

Kathy Weaver, R.N., M.P.A., J.D.
Information Services and Policy
Indiana State Department of Health

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EXECUTIVE SUMMARY

HEALTHY INDIANA – A MINORITY HEALTH PLAN FOR THE STATE OF INDIANA

Health care services, treatment outcomes, and health status have improved for the general population, but they have not improved equally or proportionately for all racial and ethnic populations. Inequalities in care, outcomes, and health status contribute to and perpetuate the existence and widening of disparities in morbidity and mortality among Indiana's American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, and Hispanic or Latino populations.

The *Report of the Secretary's Task Force on Black & Minority* Health (U.S. Department of Health and Human Services, 1985), the *Initiative to Eliminate Racial and Ethnic Disparities in Health* (U.S. Department of Health and Human Services, 1998), and *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care* (Institute of Medicine, 2002) identified and documented the existence of health disparities among racial and ethnic minority populations living in the United States. The reports focused on sets of disease-related areas that contribute to health disparities between majority and minority populations. Cancer, cardiovascular disease, chemical dependency, diabetes, HIV/AIDS, homicide, infant mortality, influenza and pneumonia, kidney disease, liver disease, and unintentional injuries are some of the more commonly cited morbidities that differentially impact racial and ethnic minority populations. *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* (The Commonwealth Fund, 2002) took the approach of looking at health disparities in relation to patient-provider communication, cultural and linguistic barriers, access to health services, and patient perceptions of respect by providers.

Indiana is rapidly becoming more diverse in its population, its language, and its culture – in both its cities and rural areas. Increasing diversity will create new challenges to the state's ability to care for the health and welfare of its residents. Using the Census 2000 reporting category of one or a combination of one or more other races, the percentage distributions of racial and ethnic populations in Indiana are 0.6 percent (American Indian or Alaska Native), 1.2 percent (Asian or Pacific Islander), 8.8 percent (Black or African American), 3.5 percent (Hispanic or Latino), and 88.6 percent (White). Most of Indiana's racial and ethnic minorities are concentrated in nine counties: Allen, Elkhart, Hamilton, Lake, Marion, Monroe, St. Joseph, Tippecanoe, and Vanderburgh.

According to the *United Health Foundation State Health Rankings* for 2002, Indiana ranks as the 22nd state in terms of overall healthiness. However, in terms of racial and ethnic disparities, Indiana ranks 40th in Years of Potential Life Lost (YPLL), with Blacks or African Americans suffering 15,120 potential years lost per 100,000 population before age 75 – a potential loss of productive life that is twice as great in the Indiana Black or African American population as it is in the Indiana White population.

In 2000 the American Public Health Association issued a Call to the Nation to Eliminate Racial and Ethnic Disparities in Health. Earlier that year the U.S. Department of Health and Human Services launched its ten-year public health agenda, *Healthy People 2010* (HP2010), which included the elimination of health disparities associated with race, ethnicity, and socioeconomic status as one of its two overarching goals. Both initiatives stated the importance of community-level partnerships with health systems, government agencies, businesses, community systems, civic and faith-based organizations, tribal organizations, philanthropic agencies, and average persons working collectively toward the common goal of eliminating disparities in health.

The Indiana Minority Health Advisory Committee (InMHAC) was created in 2000 by the Indiana State Department of Health (ISDH) to provide advice and guidance to the Department in addressing minority health disparities. The Committee subsequently was charged with the task of proposing a plan for eliminating racial and ethnic health disparities in Indiana. In preparation for its task, the Committee adopted the mission statement of "Hoosiers working together to ***HEAL the GAP*** in racial and ethnic health disparities for all people in Indiana." Its vision is to propose a plan for Hoosiers to work together to eliminate racial and ethnic health disparities for all people in Indiana through the process of **HEAL – H**ealth (promoting a state of complete physical, mental, social, and spiritual well-being), **E**quality (ensuring culturally sensitive quality health care and outcomes), **A**ccess (removing all barriers to increase the quality and years of healthy life), and **L**eadership (actualizing goals through collaborative partnerships, innovative relationships, and community involvement).

The state of Indiana, through the Indiana State Department of Health and its Minority Health Advisory Committee, hereby proposes a plan of collaboration with public and private partners to address the goal of eliminating racial and ethnic health disparities in Indiana. *Healthy Indiana – A Minority Health Plan for the State of Indiana* (the Healthy Indiana Minority Health Plan) is founded in four overarching strategic goals that capture the primary purpose for proposing, developing, and implementing a minority-specific health plan for the state of Indiana:

- Prepare evidence-based documentation of racial and ethnic health disparities in Indiana.
- Develop a plan of interventional strategies designed to eliminate racial and ethnic health disparities in Indiana.
- Identify and solidify effective public/private, community-based partnerships to help develop, implement, evaluate, and assess outcomes of the proposed interventional strategies.
- Eliminate disparities in health based on race or ethnicity among Indiana residents such that the "gap effect" for any focus area is less than five percent.

Several key, overarching issues, concepts, assumptions, and caveats must be addressed and/or acknowledged if the goals and objectives of the Plan are to be successfully realized.

ISSUES

- Health care disparity is a non-partisan issue.
- Equity in health care cannot be compromised.

- Diversity in the workforce can only be accomplished through effective recruitment and retention of underrepresented racial and ethnic minority students.
- A culturally and linguistically competent health care environment is the foundation for building a successful program to eliminate racial and ethnic health disparities.
- An understanding of the direct and indirect health and economic impact of racial and ethnic health disparities on the education and socioeconomic development of individuals and local communities must not be underestimated.

CONCEPTS

- The elimination or racial and ethnic health disparities and the attainment of health parity can be achieved only through all parties working together with a collective consciousness and commitment.
- The public must acknowledge the existence and societal importance of racial and ethnic health disparities and become owners of the process for their elimination.
- Racial and ethnic health disparities are costly to society and the current economic investment in the elimination of health disparities will generate future dividends in improved health and reduced cost.
- Comprehensive strategies are necessary to enhance opportunities for financial and geographic access to medically, culturally, and linguistically appropriate, timely, and comprehensive health care services.
- Health related behavior and practices experienced in early life establish patterns of behavior and practice that continue into adult life.
- The number and representation of racial and ethnic undergraduate, graduate and postgraduate minority students in the health professions must be increased, encouraged and supported.
- The local, health, corporate, and legislative communities must actively engage in and support the process of strategy development, implementation and evaluation.
- Health related issues must be addressed under a multidisciplinary, non-silo, interventional approach and within the broader context of health and its socio-cultural environment.

ASSUMPTIONS

- Planning for the elimination of racial and ethnic health disparities in Indiana is an iterative process.
- The economic issues and financial constraints affecting state and local governments will increasingly impact all aspects of health care planning and delivery.
- Evidence of change in health status will be incremental and difficult to assess and/or attribute to a specific intervention in the short term.
- Positive behavioral changes in lifestyle and health practices can contribute significantly to improvements in health status with a minimum investment of money and human capital or increased intensity of health care services.

CAVEATS

- The exclusion of a disease area from this Plan does not necessarily weaken its position as a major health concern, nor does it represent an oversight of the Indiana Minority Health Advisory Committee. The Committee decided that this Plan should concentrate on a workable number of disease areas that reflect significant differences in health care delivery and outcomes for the racial and ethnic minority residents of Indiana.
- The development of this Plan assumes a data-driven approach. However, state-level, population-based data are limited or absent for certain conditions, events, and/or populations, making it difficult or impossible to assess the severity of the disparity against measured benchmarks or to develop measurable objectives for the elimination of the disparity.
- Inconsistencies and gaps in the state's morbidity and mortality surveillance systems can lead to the underreporting and misreporting of epidemiologic and demographic data and incorrect inferences about the differential burdens of illness among the state's racial and ethnic minority populations.

The elimination of racial and ethnic health disparities is a complex health, environmental, behavioral, and social issue of long-standing duration that cannot be realized without considerable broad-based, culturally relevant interventions, consolidated and coordinated among many partners, and designed and sustained for long-term effects across all racial and ethnic groups. Interventional strategies must incorporate the racial, ethnic, cultural, linguistic, religious, and social factors of the target community and be tailored to address the specific socio-cultural and health care needs of the diverse racial and ethnic communities on a community-by-community basis. It is important that the local, health, corporate, and legislative communities recognize and appreciate the breadth and depth of racial and ethnic health disparities as a public health problem and understand the impact of health disparities on the general health, welfare, and economic development of Indiana and its constituent communities.

The Indiana State Department of Health, the ISDH Office of Minority Health, the ISDH Office of Cultural Diversity and Enrichment, and the Indiana Minority Health Advisory Committee are the lead entities in the preparation, development, and implementation of this Plan for eliminating racial and ethnic disparities in health among Indiana's minority populations. Related agencies and organizations, including the Interagency State Council on Black and Minority Health, the Indiana Minority Health Coalition, the Indiana Health Care Professional Development Commission, the Chronic Disease Advisory Council, the Indiana Latino Institute, the Indiana Public Health Association, the Indiana University Department of Public Health, and the local health departments are necessary complements in this collective mission to eliminate racial and ethnic health disparities.

The Healthy Indiana Minority Health Plan flows directly from the 2001 Indiana Minority Health Report and *Healthy People 2010*. The 2001 Minority Health Report was commissioned by the ISDH Office of Minority Health and the Indiana Minority Health Advisory Committee and represents an expansion of the 2000 Minority Health Disparities Report, which found continuing health disparities for heart disease, cancer, stroke, diabetes, homicide, infant mortality, HIV/AIDS, and sickle cell disease and trait. The 2001 report provides a comparison of the

leading causes of morbidity and mortality among racial and ethnic groups in Indiana with national data and benchmarks established in *Healthy People 2010*.

The Plan uses the 2001 Indiana Minority Health Report in a data-driven, evidence-based, community-centered, multidisciplinary approach to assess documented gaps in health status and identify critical areas of intervention for Indiana's racial and ethnic minority (American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, Hispanic or Latino) communities. The *Healthy People 2010* objectives that focus specifically on the areas of disease morbidity and mortality identified as immediate priorities by both the Indiana Minority Health Report and the Indiana Minority Health Advisory Committee are used to establish Indiana-specific, data-driven Healthy Indiana Minority Health 2010 (HIMH2010) objectives.

The HIMH2010 objectives were structured to mirror the nationally-focused HP2010 objectives in those areas where the national targets for the HP2010 objectives exceed the Indiana-specific levels of morbidity or mortality for any racial or ethnic minority population. The intentional link between the *Healthy People 2010* objectives and the proposed Healthy Indiana Minority Health 2010 objectives helps substantiate the rationale for the objectives and targets proposed in the Healthy Indiana Minority Health Plan. A major difficulty with this approach, however, was that Indiana baselines and targets could not be determined for many objectives due to a lack of Indiana-specific data.

The Minority Health Advisory Committee concluded that it could not address reasonably all 15 disease areas identified in the Indiana Minority Health Report, and decided to concentrate on those areas with the greatest "gap effect" in Indiana. The Plan proposes general objectives across all areas of morbidity and mortality (workforce diversity, cultural and linguistic competency) and focal objectives linked to the most prevalent conditions affecting Indiana's racial and ethnic minority populations (heart disease, cancer, stroke, asthma, diabetes, HIV/AIDS, and infant mortality). Strategic actions and interventions are proposed and tied to the Indiana-specific minority health objectives. The proposed strategies and actions that have the broadest reach and greatest potential for eliminating health disparities and producing healthy outcomes constitute the interventional priorities recommended in the first tier of proposed activity.

WORKFORCE DIVERSITY

- Diversity and competency of the workforce are vital elements to the elimination of racial and ethnic disparities in health. However, diversity in the workforce does not necessarily imply competency in the workforce's ability to respond appropriately to the cultural and linguistic differences existent within culturally and linguistically diverse populations.
- 7 objectives and 6 strategies are proposed.
- First tier (priority) objectives:
    - In allied health, nursing, medicine, dentistry, pharmacy, optometry, and public health, increase the proportion of all degrees awarded to American Indians or Alaska Natives, Blacks or African Americans, and Hispanics or Latinos to levels comparable to their respective proportions in the Indiana population.

CULTURAL AND LINGUISTIC COMPETENCE

- Cultural beliefs, values, attitudes, experiences, and practices across diverse populations help form and influence variations in health understanding and behavior, and potentially impact interaction and communication between patient and provider.
- 9 objectives and 19 strategies are proposed.
- First tier (priority) objectives:
    - Improve data monitoring and evaluation of programs and efforts to enhance cultural competency in health care.
    - Promote a culturally and linguistically competent system of health care that acknowledges and incorporates all levels of importance of culture and language, the cultural strengths associated with people and communities, and the assessment of cross-cultural relations.
    - Promote better understanding of strategies on how to serve diverse populations.
    - Reduce access to care barriers that foster racial and ethnic disparities in health.
    - Reduce systemic barriers that impact structure, logistics, and processes of care and foster racial and ethnic disparities in health.
    - Reduce provider-based barriers that impact health care encounters, provider-patient communication and foster racial and ethnic disparities in health.

HEART DISEASE

- Heart disease is the leading cause of death for every race and ethnic group in Indiana, except in the Asian or Pacific Islander population.
- 7 objectives and 15 strategies are proposed.
- 4 unsupported objectives (no Indiana-specific data) are proposed.
- First tier (priority) objectives:
    - Reduce coronary heart disease deaths among Indiana's Black or African American population from 243.5 coronary heart disease deaths per 100,000 Black or African American persons (2000) to 170.5 deaths per 100,000 Black or African American persons (InMHAC target of 30% improvement).
    - Reduce the proportion of adults among Indiana's Black or African American population with high blood pressure from 35.6% of Black or African American adults aged 20 years and older (2001) to 16.0% (HP2010 target).
    - Increase the proportion of adults among Indiana's Hispanic or Latino population who have had their blood cholesterol checked within the preceding 5 years from 53.1% of Hispanic or Latino adults aged 18 years and older (2001) to 85.0% (InMHAC target).

CANCER

- Cancer is the second leading cause of death for every race and ethnic group in Indiana, except in the Asian or Pacific Islander population where it is the leading cause of death.
- 12 objectives and 22 strategies are proposed.
- 2 unsupported objectives (no Indiana-specific data) are proposed.
- First tier (priority) objectives:

- Reduce the overall cancer death rate among Indiana's Black or African American population from 274.9 cancer deaths per 100,000 Black or African American persons (2000) to 192.4 cancer deaths per 100,000 Black or African American persons (InMHAC target of 30% improvement).
- Reduce the lung and bronchus cancer death rate for males among Indiana's Black or African American population from 110.7 lung and bronchus cancer deaths per 100,000 Black or African American males (2000) to 86.3 deaths per 100,000 Black or African American males (HP2010 target of 22% improvement).
- Reduce the lung and bronchus cancer death rate for females among Indiana's Black or African American population from 53.7 lung and bronchus cancer deaths per 100,000 Black or African American females (2000) to 41.9 deaths per 100,000 Black or African American females (HP2010 target of 22% improvement).
- Reduce the breast cancer death rate for females among Indiana's Black or African American population from 39.9 breast cancer deaths per 100,000 Black or African American females (2000) to 31.9 deaths per 100,000 Black or African American females (HP2010 target of 20% improvement).
- Reduce the death rate from cancer of the uterine cervix among Indiana's Black or African American population from 4.9 cervical cancer deaths per 100,000 Black or African American females (2000) to 3.3 deaths per 100,000 Black or African American females (HP2010 target of 33% improvement).
- Reduce the colorectal cancer death rate for males among Indiana's Black or African American population from 42.9 colorectal cancer deaths per 100,000 Black or African American males (2000) to 28.3 deaths per 100,000 Black or African American males (HP2010 target of 34% improvement).
- Reduce the colorectal cancer death rate for females among Indiana's Black or African American population from 21.4 colorectal cancer deaths per 100,000 Black or African American females (2000) to 14.1 deaths per 100,000 Black or African American females (HP2010 target of 34% improvement).
- Increase the proportion of adults among Indiana's Black or African American population who receive a colorectal cancer screening examination from 38.7% (2001) to 50.0% of Black or African American adults aged 50 years and older who have ever received sigmoidoscopy (HP2010 target).
- Reduce the prostate cancer death rate among Indiana's Black or African American population from 73.9 prostate cancer deaths per 100,000 Black or African American males (2000) to 44.3 deaths per 100,000 Black or African American males (InMHAC target of 40% improvement).
- Reduce the oropharyngeal cancer death rate among Indiana's Black or African American population from 5.1 oropharyngeal cancer deaths per 100,000 Black or African American persons (2000) to 3.1 deaths per 100,000 Black or African American persons (InMHAC target of 40% improvement).

STROKE

- Stroke is the third leading cause of death for Blacks or African Americans in Indiana.
- 7 objectives and 15 strategies are proposed.
- 4 unsupported objectives (no Indiana-specific data) are proposed.
- First tier (priority) objectives:

- Reduce stroke deaths among Indiana's Black or African American population from 92.3 deaths from stroke per 100,000 Black or African American persons (2000) to 55.4 deaths per 100,000 Black or African American persons (InMHAC target of 40% improvement).
- Reduce the proportion of adults among Indiana's Black or African American population with high blood pressure from 35.6% of Black or African American adults aged 20 years and older (2001) to 16.0% (HP2010 target).
- Increase the proportion of adults among Indiana's Hispanic or Latino population who have had their blood cholesterol checked within the preceding 5 years from 53.1% of Hispanic or Latino adults aged 18 years and older (2001) to 85.0% (InMHAC target).

ASTHMA

- Asthma is the fourth leading cause of death for American Indians or Alaska Natives in Indiana.
- 2 objectives and 16 strategies are proposed.
- 11 unsupported objectives (no Indiana-specific data) are proposed.
- First tier (priority) objectives:
  - Reduce asthma deaths among Indiana's Black or African American population from 6.3 asthma deaths per 100,000 Black or African American persons (2000) to 3.8 deaths per 100,000 Black or African American persons (InMHAC target of 40% improvement).

DIABETES

- Diabetes is the fourth leading cause of death for American Indians or Alaska Natives, Asians or Pacific Islanders, and Blacks or African Americans and the fifth leading cause of death for Hispanics or Latinos in Indiana.
- 3 objectives and 13 strategies are proposed.
- 7 unsupported objectives (no Indiana-specific data) are proposed.
- First tier (priority) objectives:
  - Reduce the prevalence of diabetes among Indiana's Black or African American population from 53.0 cases of diabetes per 1,000 Black or African American persons (1999) to 26.5 cases per 1,000 Black or African American persons (InMHAC target of 50% improvement).
  - Reduce the diabetes death rate among Indiana's Black or African American population from 57.4 deaths per 100,000 Black or African American persons (2000) to 28.7 deaths per 100,000 Black or African American persons (InMHAC target of 50% improvement).
  - Reduce the diabetes death rate among Indiana's Hispanic or Latino population from 51.7 deaths per 100,000 Hispanic or Latino persons (2000) to 25.9 deaths per 100,000 Hispanic or Latino persons (InMHAC target of 50% improvement).

HIV/AIDS

- The impact of HIV/AIDS within minority communities has been devastating, especially among Black or African American males – it is estimated that 1 in 50 Black or African American men and 1 in 160 Black or African American women are infected with HIV.
- 4 objectives and 6 strategies are proposed.

- 2 unsupported objectives (no Indiana-specific data) are proposed.
- First tier (priority) objectives:
    - Reduce the prevalence of HIV/AIDS among Indiana's Black or African American population from 416.6 cases of HIV/AIDS per 100,000 Black or African American persons (2002) to 250.0 cases of HIV/AIDS per 100,000 Black or African American persons (InMHAC target of 40% improvement).
    - Reduce the prevalence of HIV/AIDS among Indiana's Hispanic or Latino population from 131.9 cases of HIV/AIDS per 100,000 Hispanic or Latino persons (2002) to 79.1 cases of HIV/AIDS per 100,000 Hispanic or Latino persons (InMHAC target of 40% improvement).
    - Reduce the prevalence of AIDS among Indiana's Black or African American population from 346.6 cases of AIDS per 100,000 Black or African American persons (2002) to 232.2 cases of AIDS per 100,000 Black or African American persons (InMHAC target of 33% improvement).

INFANT MORTALITY

- Indiana's Black or African American infant mortality rate is more than double the rate for Indiana's Hispanics or Latinos and Whites – Blacks or African Americans also are ranked the highest in neonatal deaths.
- 4 objectives and 25 strategies are proposed.
- First tier (priority) objectives:
    - Reduce infant deaths (within 1 year) among Indiana's Black or African American population from 15.9 per 1,000 live births (2000) to 6.7 per 1,000 live births (rate for Indiana White population).
    - Reduce low birth weight (LBW) among Indiana's Black or African American population from 12.7% of live births (2000) to 6.7% of live births (percent for Indiana White population).
    - Reduce low birth weight (LBW) among Indiana's Asian or Pacific Islander population from 7.3% of live births (2000) to 6.7% of live births (percent for Indiana White population).
    - Reduce very low birth weight (VLBW) among Indiana's Black or African American population from 2.9% of live births (2000) to 1.2% of live births (percent for Indiana White population).

To complement the general and focal objectives, the Plan proposes a series of recommendations relative to Public Policy, ISDH Program Development and/or Expansion, Health Services, Health Promotion and Communication Strategies, and Public/Private/Community Partnerships.

PUBLIC POLICY RECOMMENDATIONS

- Ensure that ISDH funding criteria reflect the special needs of priority communities by linking ISDH grants programmatically to the Healthy Indiana Minority Health 2010 objectives.
- Establish Minority Health Month in Indiana as a permanent health theme for April each year.
- Establish and support an external Racial and Ethnic Minority Epidemiology Center.
- Establish an interagency committee to oversee disease surveillance, review health status indicators, evaluate demographic changes, assess barriers to health care, communicate data, share

information across programs, and monitor progress toward the elimination or racial and ethnic health disparities in Indiana.

- Establish legislative policies that direct state officials to finds ways to ensure equal access to financial coverage of health care services for all Indiana residents.
- Establish statewide policies that direct state and local public school authorities to address issues of nutrition in their cafeteria and vending machines.
- Establish statewide policies that direct state and local public school authorities to address issues of physical fitness.
- Establish and operate school-based clinics and/or school nurse programs in public primary and secondary schools with high enrollments of racial and ethnic minority students.
- Partner with the corporate community to make available to employees worksite-based clinics and on-site health care services.
- Develop and implement state health care purchasing strategies that support opportunities for eliminating racial and ethnic health disparities.
- Establish a Health Professions Scholarship Fund to recruit underrepresented racial and ethnic minority students in Indiana into the health professions.
- Develop criteria for defining local racial and ethnic minority health professional shortage areas (MHPSAs).
- Create and expand financial incentives to support racial and ethnic minority health professionals who locate in MHPSAs.
- Provide reimbursement mechanisms to cover the cost of patient education and counseling with regard to diet, exercise, and other lifestyle modifications.

ISDH PROGRAM DEVELOPMENT AND/OR EXPANSION RECOMMENDATIONS

- Issue an ISDH "Call to Action" on health disparities.
- Expand the ISDH Epidemiology Resource Center and Surveillance Investigation Unit.
- Produce and release to the public on a biennial basis an Indiana Minority Health Report and Chart Book.
- Conduct a series of community/county-focused town meetings or summits.
- Develop and implement state grant and contract requirements that ensure compliance with core cultural competencies among all recipients of ISDH grants and contracts.
- Provide periodic technical assistance workshops for minority community-based and tribal organizations.
- Implement a grant and contract review and approval process that considers the infrastructure and capability of the applicant to produce the requested deliverables.
- Partner with and/or support minority community-based and tribal organizations and colleges and universities in responding to grant announcements from the U.S. Office of Minority Health.
- Develop and distribute personal health profile forms and action plan worksheets to racial and ethnic minority populations to support chronic disease self management and promote "personal responsibility for health."
- Ensure that every racial and ethnic minority patient receives appropriate and timely assessments of lifestyle, body mass index, blood pressure, cholesterol, blood glucose, and triglyceride levels, and that each patient records the results of his or her assessment on their personal health profile form.

- Increase opportunities within racial and ethnic populations to screen and provide follow-up therapeutic interventions for elevated blood pressure, cholesterol, blood glucose, and triglyceride levels.
- Create a special committee to: 1) explore ideas for expanding the pool of racial and ethnic minorities in the health professions; 2) search for funding to support outreach and recruitment efforts; and 3) periodically assess the provider infrastructure.
- Contract with the DHHS Region V Office of Minority Health to plan and conduct a Midwest Regional Conference on Racial and Ethnic Health Disparities.

HEALTH SERVICES RECOMMENDATIONS

- Develop programs to educate and inform health care providers, patients, and payers on the efficacy and challenges of intervention and evidence-based disease management within diverse populations.
- Integrate and institutionalize minimum standards of education for culturally and linguistically appropriate services throughout the curricula of the state's health professions schools, academic programs, and institutions and into the continuing professional education programs of all state licensed health professions.
- Develop and distribute a community health resource/information clearing house list and description of all health care resources, provider services, and support networks available to community residents.
- Increase the number and/or service areas of community and rural health centers, Indian Health Service clinics, and provider services.
- Encourage the state's health professions schools to expand outreach clinic services to underserved minority communities.
- Partner with the Indiana Department of Education and the state's K-12 and higher educational institutions to implement programs to increase the number of racial and ethnic minority students in the state's health professions schools.
- Encourage the state's health professions schools to aggressively recruit and hire faculty that are representative of Indiana's racial and ethnic minority populations.
- Expand clinical practice opportunities and student externships in health education and social work programs to facilitate changes in health related behavior and compliance.
- Encourage the Indiana University School of Medicine Department of Public Health to identify racial and ethnic health disparities as a major area of academic, clinical, and research focus and to establish an academic Center of Excellence for the elimination or racial and ethnic health disparities in Indiana.

HEALTH PROMOTION AND COMMUNICATION STRATEGIES RECOMMENDATIONS

- Establish minority health liaisons in each major division of state government.
- Establish minority health liaisons at each of the state's health professions schools.
- Establish community and tribal health liaisons in every racial and ethnic minority community.
- Promote the development of local level partnerships for community-based strategic assessment, planning and goal-setting.
- Engage the media, communication, and advertising industries and sponsors to help with social marketing efforts, awareness campaigns, and communication of disease prevention and health promotion strategies, activities, and practices.

- Engage community relevant venues with high traffic of racial and ethnic minority populations to foster social environments and networks that peer educate and peer promote healthy lifestyles and healthy behavior.
- Encourage local hospitals, community health centers, and health care professionals to sponsor and/or host community-centered health fairs.

PUBLIC/PRIVATE/COMMUNITY PARTNERSHIPS RECOMMENDATIONS

- Continue and expand industry and public health forums and workshops.
- Encourage each major corporate entity in Indiana to adopt at least one of the Plan's disease focus areas and concentrate work site wellness programs and activities on improving health indicators among its employee population.
- Encourage each major corporate entity in Indiana to adopt a high health risk racial or ethnic neighborhood community and sponsor community health events and activities designed to improve the health status of community residents.
- Partner with the food industry to provide coupons for discounts on vegetables and other healthy foods for highly at-risk and economically vulnerable racial and ethnic minority populations.
- Partner with the restaurant industry to clearly label low-fat menu options and provide discounts on half-portion orders.
- Develop and expand community-level partnerships to facilitate outreach to "yet to be reached" and "hardly reached" priority populations.
- Develop and expand community-level partnerships to create and maintain community environments that are supportive of physical activity.

The Committee arranged meetings with ISDH program managers to get input on what the relevant programs were doing currently in the area of minority health. Individuals outside and inside the Indiana State Department of Health and representative of a broad base of knowledge and experience were identified and invited to be part of a review group to comment on the working draft before it was advanced in its final form to the Indiana State Health Commissioner.

This Plan proposes benchmarks and strategies to help state, local, and community partners and stakeholders chart future courses of action and make important decisions about the allocation of scare resources to adjust the imbalance in health status among Indiana's racial and ethnic minority populations. Hopefully, adoption and implementation of the Plan will set in place mechanisms to help ensure the availability and accessibility of a uniformly high quality of health care that produces improved and equitable health care outcomes for all Indiana residents regardless of their race, ethnicity, culture, gender, age, education, socio-economic status, or geographic residence.

The health of racial and ethnic minority populations living and working in Indiana is reflective of the health of the state, and the state cannot be healthy in the absence of a healthy minority constituency. Improvements in the health of Indiana's minority populations will benefit the entire state and translate into improvements in the health and productive potential of Indiana's overall population.

BACKGROUND

"Of all forms of inequality, injustice in health care is the most shocking and inhumane."

The Reverend Dr. Martin Luther King, Jr.

In 1985 Secretary Margaret Heckler of the U.S. Department of Health and Human Services (DHHS) released the seminal *Report of the Secretary's Task Force on Black & Minority Health*, bringing public attention and focus to the problem, magnitude and severity of disparities in health and health care found among racial and ethnic minority populations in the U.S. The report identified six disease related areas that accounted for more than 80 percent of the health disparity – described in terms of 60,000 "excess deaths" per year that would not have occurred if mortality rates were the same for all Americans. Thirteen years later, DHHS launched the 1998 *Initiative to Eliminate Racial and Ethnic Disparities in Health* to refocus the Department's attention on eliminating disparities in the six targeted areas of infant mortality, cardiovascular disease, cancer screening and management, HIV/AIDS, child and adult immunizations, and diabetes.

The 2002 Institute of Medicine (IOM) report, *Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care*, restated and further amplified the significance of the persistent and increasing prevalence of disparities in health care for racial and ethnic minorities in the United States. The IOM report suggested that a lower quality of care is experienced by racial and ethnic minorities, and that the lower quality of care frequently is independent of financial access. According to the 2001 Behavioral Risk Factor Surveillance System, 61% of Indiana Hispanics or Latinos reported having a personal doctor or health care provider, compared to 73% of Blacks or African Americans and 80% of Whites. Although racial and ethnic minorities, especially Hispanics or Latinos, are at greater risk for being uninsured and not having a usual source of health care, studies reported out of the Agency for Healthcare Research and Quality suggest that racial and ethnic disparities in health cannot be explained solely on the basis of income and insurance effects. The Commonwealth Fund's study on *Diverse Communities, Common Concerns: Assessing Health Care Quality for Minority Americans* reported disparities on such health care quality measures as effective patient-provider communication, response to cultural and linguistic barriers, access to health services, and the perception of respect by health care providers.

Health Care Coverage in Indiana, 2001

- **Black or African American: 82.8%**
- **Hispanic or Latino: 63.6%**
- **White: 87.8%**
- **Indiana Average: 86.0%**

The problem of racial and ethnic health disparities in America extends down to the level of the individual states, including the state of Indiana. Although Indiana is not as diverse as the nation as a whole, it still is reflective of the nation in terms of its constituent population. Census 2000 shows that the Black or African American population is the largest racial or ethnic group in

Indiana at 8.4% of the state population, and that the American Indian or Alaska Native population is the smallest at 0.3%. However, those percentages reflect the population of persons reporting only one race. When the population of persons reporting one or a combination of one or more other races is examined, the percentages increase for all groups, but most dramatically for the American Indian or Alaska Native population – doubling from 0.3% of the population to 0.6% of the population. For the purposes of this Plan, the more inclusive multiracial percentages (e.g., American Indian or Alaska Native population of 0.6% instead of 0.3%) will be used to set population-based statistical targets.

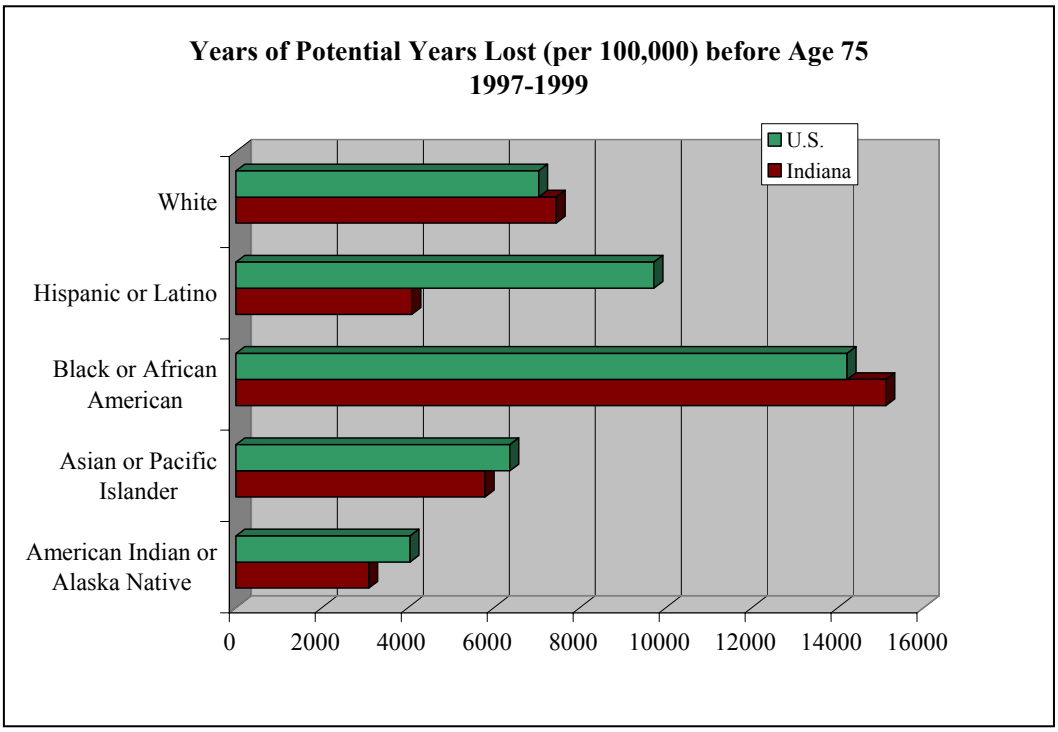
RACE OR ETHNICITY	ONE RACE		IN COMBINATION WITH ONE OR MORE OTHER RACES	
	Percent		Percent	
	Indiana	United States	Indiana	United States
American Indian or Alaska Native	0.3	0.9	0.6	1.5
Asian or Pacific Islander	1.0	3.6	1.2	4.2
Black or African American	8.4	12.3	8.8	12.9
Hispanic or Latino (any race)	3.5	12.5	3.5	12.5
White	87.5	75.1	88.6	77.1

Each of the racial and ethnic groups is on a growth curve, with the Hispanic or Latino population in Indiana almost doubling between 1990 and 2000. As the population continues its consistent growth toward greater diversity, the likelihood of a growing health disparity for Indiana's racial and ethnic minority populations increases in the absence of a planned intervention. The Indiana counties with the largest populations of racial and ethnic minority residents are:

American Indian or Alaska Native:	Marion, Lake, Allen, St. Joseph, Elkhart
Asian or Pacific Islander:	Marion, Tippecanoe, Allen, Hamilton, Monroe
Black or African American:	Marion, Lake, Allen, St. Joseph, Vanderburgh
Hispanic or Latino:	Lake, Marion, Elkhart, Allen, St. Joseph

The *United Health Foundation State Health Rankings - 2002 Edition* lists Indiana 22nd among all states in terms of its overall ranking of the healthiness of the state. However, in terms of disparities between races and ethnic groups, Indiana ranks 40th on the premature mortality index of Years of Potential Life Lost (YPLL). An almost five-fold difference exists between the YPLL for American Indians (on the low end at 3,091 potential years lost per 100,000 before age 75) and Blacks or African Americans (on the high end at 15,120 potential years lost per 100,000 before age 75). A two-fold difference exists in the disparity in YPLL between Indiana's White and Black populations, indicating that the potential loss of productive life is twice as great in the Indiana Black or African American population as it is in the Indiana White population.

Comparing Indiana rates to U.S. rates, the potential years lost per 100,000 population are higher in Indiana for Blacks or African Americans and Asian Americans than they are for those populations nationally.



United Health Foundation State Health Rankings – 2002 Edition

At its 2000 Annual Meeting the American Public Health Association (APHA) issued a Call to the Nation to Eliminate Racial and Ethnic Disparities in Health in an effort to coalesce individuals and organizations throughout the country under the common goal of eliminating racial and ethnic health disparities in the U.S. *Healthy People 2010* (HP2010) is the U.S. Department of Health and Human Services' initiative that articulates the nation's public health objectives for the next ten years.

The 467 Healthy People objectives cover 28 focus areas are founded on two overarching goals*: increasing the quality and years of healthy life, and eliminating health disparities associated with race, ethnicity, and socioeconomic status*.

Response to the APHA Call to the Nation and attainment of the HP2010 goals and objectives will require the development and expansion of partnerships at the level of the community, involving health systems, government agencies, businesses, community systems, civic and faith-based organizations, tribal organizations, philanthropic agencies, and average persons working collectively toward the common goal of eliminating disparities in health.

The state of Indiana, through the Indiana State Department of Health and its Minority Health Advisory Committee, hereby proposes a plan of collaboration with public and private partners to address the *Healthy People 2010* goal of eliminating in Indiana health disparities associated with race, ethnicity, and socioeconomic status.

	FIVE LEADING CAUSES OF DEATH IN INDIANA BY RACE OR ETHNICITY 2000				
CAUSE OF DEATH	**American Indian or Alaska Native**	**Asian or Pacific Islander**	**Black or African American**	**Hispanic or Latino**	**White**
Accidents	3	3		3	5
Cancer	2	1	2	2	2
Cerebrovascular Disease	4	5	3	4	3
Chronic Lower Respiratory Disease	4				4
Diabetes	4	4	4	5	
Heart Disease	1	2	1	1	1
Homicide	4		5		

INDIANA MINORITY HEALTH ADVISORY COMMITTEE

The Indiana Minority Health Advisory Committee (InMHAC) was created in 2000 by the Indiana State Department of Health (ISDH) under the Indiana Minority Health Initiative to provide advice and guidance to the ISDH in addressing minority health disparities. The Committee subsequently was charged with the task of proposing a plan for eliminating racial and ethnic health disparities in Indiana. Membership on the InMHAC is by appointment of the State Health Commissioner and is representative of the diversity of people, organizations, and issues affected by its mission.

MISSION STATEMENT

Hoosiers working together to ***HEAL the GAP*** in racial and ethnic health disparities for all people in Indiana.

VISION STATEMENT

The Indiana Minority Health Advisory Committee will propose a plan for Hoosiers to work together to eliminate racial and ethnic health disparities for all people in Indiana through the

Health	– promoting a state of complete physical, mental, social, and spiritual well-being.
Equality	– ensuring culturally sensitive quality health care and outcomes.
Access	– removing all barriers to increase the quality and years of healthy life.
Leadership	– actualizing goals through collaborative partnerships, innovative relationships, and community involvement.

process of **HEAL**:

KEY ACTIONS

The key actions to be undertaken by the Indiana Minority Health Advisory Committee include:

- identify additional data to be collected and analyzed on minority health disparities;
- develop plans that will provide effective interventions to address those disparities;
- develop and offer cultural competency to staff and grantees;
- identify minority vendors in the community and contract with them when possible;
- develop, identify, and offer additionally needed technical assistance to improve ISDH grantee performance in serving the minority community;
- monitor grantee performance and outcomes in relation to serving the minority community; and
- intervene by recommendation when grantee performance is judged inadequate as reflected in patient satisfaction surveys and annual grantee reports.

INITIAL ACTIVITY

One of the first responsibilities of the Committee was to respond with recommendations to two reports produced by the ISDH Office of Minority Health. The Minority Health Disparities Report and the report of the Forum on Chronic Diseases in Minority Populations in Indiana listed a variety of concerns and factors that are believed to influence the status of minority health in Indiana. The Minority Health Disparities Report was designed to focus attention on the issue of racial and ethnic health disparities in Indiana by comparing the leading causes of death among racial and ethnic groups in Indiana with national data. The report of the Forum on Chronic Diseases in Minority Populations in Indiana was produced as a summary of the testimony and comments received during a public forum held in the legislative chambers of the State House and jointly sponsored by the DHHS Region V Office of Minority Health and ISDH to discuss the impact chronic diseases are having on minority populations in Indiana. A common theme of both reports was the need for a more educated public regarding the prevention, detection, and treatment of chronic diseases.

The Committee responded to the issues identified in both reports by generating a list of recommendations that was submitted to the Office of Minority Health for consideration by ISDH. Many of the reports' recommendations are mutually relevant to the issues and concerns expressed in the Healthy Indiana Minority Health Plan, such as recommendations to:

- provide cultural competency training to health care professionals and culturally and socio-economically sensitive language information and services to patients and the public;
- create resource centers, speakers bureaus, and clearinghouses of information on chronic diseases and make them available in and accessible to racial and ethnic minority communities; or
- establish a comprehensive and integrated health data collection system and registry on health care outcomes, the adequacy and quality of services, the availability of culturally and linguistically appropriate provider-patient interactions, stratified by racial and ethnic minority classification and geopolitical residence (e.g., city and county).

The relevant recommendations from the Committee's review of the Minority Health Disparities Report and the Forum report are incorporated into the recommendations provided in this Healthy Indiana Minority Health Plan.

INTERAGENCY STATE COUNCIL ON BLACK AND MINORITY HEALTH

In 1988, the Indiana General Assembly enacted legislation that created the Interagency State Council on Black and Minority Health. *Indiana Code 16-46-6* directed the Indiana State Department of Health to establish the Interagency State Council on Black and Minority Health with representation from the Indiana House of Representatives, Indiana Senate, Governor's Office, State Health Commissioner's Office, and other state agencies to:

- identify and study the special health care needs and health problems of minorities;
- examine the factors and conditions that affect the health of minorities;
- examine the health care services available to minorities in the public and private sector and determine the extent to which these services meet the needs of minorities;
- study the state and federal laws concerning the health needs of minorities;
- examine the coordination of services to minorities and recommend improvements in the delivery of services;
- examine funding sources for minority health care;
- examine and recommend preventive measures concerning the leading causes of death or injury among minorities, including: heart disease; stroke; cancer; intentional injuries; accidental death and injury; cirrhosis; diabetes; infant mortality; HIV and acquired immune deficiency syndrome; examine the impact of adolescent pregnancy, mental disorders, substance abuse, sexually transmitted and other communicable diseases, lead poisoning, long term disability and aging, and sickle cell anemia on minorities;
- monitor the Indiana minority health initiative and other public policies that affect the health status of minorities.

The Council is mandated legislatively to review and assess the health status of minorities in the state of Indiana, and submit to the Governor and the General Assembly before November 1 of each year an annual report on its findings, conclusions, and recommendations.

In 1992, the Interagency State Council on Black and Minority Health, in collaboration with the Indiana Black Legislative Caucus and the Indiana Minority Health Coalition, submitted the Five-Year Strategic Plan for Black and Minority Health to the Governor and Legislature. The General Assembly, in their acknowledgment of the needs addressed in the Five-Year Strategic Plan, passed legislation and appropriations for minority health initiatives.

The Indiana Minority Health Advisory Committee and the Interagency State Council on Black and Minority Health have common members and similar missions and goals. The two groups schedule joint meetings at frequent intervals to develop and review complementary work agendas, and to avoid unnecessary duplication of effort. The efficient attainment of mutual objectives is contingent on the further development and expansion of a cooperative working relationship between the Advisory Committee and the Interagency Council. Because of its legislated role in advancing minority health, the Interagency Council must be an integral partner in the evolution and implementation of the Healthy Indiana Minority Health Plan.

INDIANA STATE DEPARTMENT OF HEALTH

The Indiana State Department of Health (ISDH) is the primary governmental agency with responsibility and oversight for the health of the people who live and work in Indiana. The mission of ISDH is to promote, protect, and provide for the public health of Indiana citizens. According to the Office of Minority Health Resource Center, Indiana is one of 34 states that have established an official minority health entity, such as an office, commission, council, center, branch, project, or other unit either through executive or legislative branch action.

OFFICE OF MINORITY HEALTH

In 1991, the State Health Commissioner created and staffed the Office of Special Populations. The Office, as part of the Public Health Services Commission, was reorganized and renamed the Office of Minority Health (OMH). The OMH focuses on efforts to reduce disparities in preventable health conditions of minorities in the state of Indiana, and is administered through the Indiana State Department of Health.

The OMH works cooperatively with the Interagency State Council on Black and Minority Health, local minority health coalitions, and various other institutions within minority communities to address the objectives and recommendations contained in the Indiana Minority Health Initiative.

The goal of the Office of Minority Health is to address the racial and ethnic disparities in health through minority health initiatives and support of programs and strategies developed specifically to provide better and more efficient health delivery systems. Its mission is to identify and assess the health needs of minority populations who experience problems in gaining access to preventive and basic health care. The OMH coordinates, facilitates, and monitors community-based programs tailored to meet the needs of minority populations. The OMH also will:

- ensure that health related issues become part of the agendas of outside programs as they relate to underserved populations; and
- maintain open dialogues with outside agencies in an effort to keep abreast of concerns, trends, and problems to identify gaps, barriers, and duplication in services.

OFFICE OF CULTURAL DIVERSITY AND ENRICHMENT

The Office of Cultural diversity and Enrichment was created in March 2001 to help address the public health needs of Indiana's racial and ethnic minority populations and to reduce major barriers leading to disparate care and health care outcomes. ISDH recognized the need to place a stronger emphasis on cultural competency for health care professionals practicing in the state and for employees of the Indiana State Department of Health.

The Office of Cultural Diversity and Enrichment offers a two-day Cultural Competence Workshop twice a month. The workshops emphasize cultural knowledge and differences, strategies for working with racial and ethnic populations, principles of interpreter services, and discussion of different cultures. An Advanced Cultural Competency Workshop is

offered for those health care professionals who have attended the two-day workshop to expand learning about the field of cultural competence in health care, expand knowledge of the general characteristics of culture and ethnic groups in the U.S., and develop techniques for understanding each client as a unique person within his or her ethnic and racial heritage.

The Office of Cultural Diversity and Enrichment has responsibility for preparing cultural sensitivity and awareness training language to be used in all ISDH grants, requests for proposals, and contracts. State contracts stipulate the need for all grantees (e.g., local health departments, community health centers, etc.) to provide some sort of cultural enrichment and diversity training as a requirement for the receipt of state funds. The Office has developed a basic to advanced training program for those who apply for state contracts.

INDIANA MINORITY HEALTH INITIATIVE

The Indiana Minority Health Initiative was created by the Indiana Legislature under *Indiana Code 16-46-11*, and thereby extends to the Indiana State Department of Health responsibility for:

- developing and implementing a state structure more conducive to addressing the health disparities of minority populations in Indiana;
- monitoring minority health progress;
- establishing policy;
- funding minority health programs, research, and other initiatives;
- providing data and technical assistance through interdepartmental coordination to local minority health coalitions for the development of health interventions;
- providing minority health research, data, and resource information through the state health data center to local organizations interested in minority health;
- staffing a minority health hotline that establishes linkages with other health and social service hotlines and local coalitions;
- developing and implementing an aggressive recruitment and retention program to increase the number of minorities in the health and social services professions;
- developing and implementing an awareness program that will increase knowledge among health and social service providers regarding the special needs of minority populations;
- developing and implementing culturally and linguistically appropriate health promotion and disease prevention programs that emphasize the avoidance of risk factors for conditions affecting minorities;
- providing the state support necessary to ensure the continued development of existing minority health coalitions and to develop coalitions in other areas targeted for minority health intervention;
- appointing a state funded coordinator for each of the counties with existing coalitions to provide community planning and needs assessment assistance and assist in the development of local minority health intervention plans;
- appointing and assigning regional consultants to serve as liaisons between ISDH and local coalitions to coordinate resources in the development of local coalitions, provide assistance to and monitor local coordinators in the development of local intervention plans, serve as the barometer to ISDH on the minority health concerns of local coalitions, assist in coordinating minority community input on state policies and programs, serve as linkages with ISDH and local minority health coordinators, and monitor the progress;
- providing funding, within the limits of appropriations, to support preventive health, education, and treatment programs in minority communities that are developed, planned, and evaluated by approved organizations; and
- providing assistance to local communities to obtain funding for the development of a health care delivery system to meet the needs, gaps, and barriers identified in the local plans.

INDIANA MINORITY HEALTH REPORT

The 2001 Indiana Minority Health Report was commissioned by the ISDH Office of Minority Health and the Indiana Minority Health Advisory Committee to provide a comparison of the leading causes of morbidity and mortality among racial and ethnic groups in Indiana with national data and benchmarks established in *Healthy People 2010*. The report was prepared by the ISDH Epidemiology Center and represents a focused observation and snapshot of the health status of racial and ethnic minorities living in Indiana.

The 2001 Indiana Minority Health Report is an expansion of the 2000 Minority Health Disparities Report, which found continuing health disparities for heart disease, cancer, stroke, diabetes, homicide, infant mortality, HIV/AIDS, and sickle cell disease and trait. The 2001 report provides information to assess the changing health status of the racial and ethnic communities of Indiana, as well as serving as a guide for developing resources and interventions in areas of need and reducing risk factors that contribute to higher levels of adverse health conditions among Indiana's racial and ethnic minorities.

The Report identified 15 disease areas requiring focused attention in Indiana. The identification of the15 disease areas was based on the epidemiology of those diseases and particularly their prevalence and impact within and upon Indiana's racial and ethnic minority populations. The 15 areas are listed in the following table:

2001 INDIANA MINORITY HEALTH REPORT DISEASE FOCUS AREAS	
Heart disease	Suicide
Malignant neoplasms (cancer)	HIV/AIDS
Cerebrovascular disease (stroke)	Cirrhosis (liver disease)
Chronic obstructive pulmonary disease/chronic lower respiratory disease (asthma)	Kidney disease/end stage renal disease
Unintentional injuries/accidents or adverse events	Conditions that originate in the perinatal period
Pneumonia and influenza	Homicide
Diabetes	Alzheimer's disease
Septicemia	

The Indiana Minority Health Report represents the primary data resource for determining the objectives and targets contained in the Healthy Indiana Minority Health Plan.

DEVELOPING *HEALTHY INDIANA – A MINORITY HEALTH PLAN FOR THE STATE OF INDIANA* (THE MINORITY HEALTH PLAN)

THE CHALLENGE

Health care services, treatment outcomes, and health status have improved for the general population, but they have not improved equally or proportionately for all racial and ethnic populations. Inequalities in care, outcomes, and health status contribute to and perpetuate the existence and widening of disparities in morbidity and mortality among Indiana's American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, and Hispanic or Latino populations.

The health of racial and ethnic minority populations living and working in Indiana is reflective of the health of the state, and the state cannot be healthy in the absence of a healthy minority constituency. Improvements in the health of Indiana's minority populations will benefit the entire state and translate into improvements in the health and productive potential of Indiana's overall population.

The rapidly changing dynamics and shifting demographics of the Indiana population and its constituent subpopulations increase the importance and relevance of programs and activities designed to increase health care literacy and cultural competency, decrease financial, geographic, and cultural barriers, and improve the quality of care and health care outcomes for Indiana residents.

The elimination of racial and ethnic health disparities is a complex health, environmental, behavioral, and social issue of long-standing duration that cannot be realized without considerable broad-based, culturally relevant interventions, consolidated and coordinated among many partners, and designed and sustained for long-term effects across all racial and ethnic groups. Interventional strategies must incorporate the racial, ethnic, cultural, linguistic, religious, and social factors of the target community and be tailored to address the specific socio-cultural and health care needs of the diverse racial and ethnic communities on a community-by-community basis.

However, and most importantly, the local, health, corporate, and legislative communities must recognize and appreciate the breadth and depth of racial and ethnic health disparities as a public health problem and understand the impact of health disparities on the general health, welfare, and economic development of Indiana and its constituent communities.

The challenge, therefore, is to ensure the availability and accessibility of a uniformly high quality of health care that produces improved and equitable health care outcomes for all Indiana residents regardless of their race, ethnicity, culture, gender, age, education, socio-economic status, or geographic residence.

GOALS

Healthy Indiana – A Minority Health Plan for the State of Indiana (the Healthy Indiana Minority Health Plan) is founded in four overarching strategic goals that capture the primary purpose for proposing, developing, and implementing a minority-specific health plan for the state of Indiana. The attainment of the four goals is linked closely to several factors that are critical to the Plan's success.

STRATEGIC GOALS

- Prepare evidence-based documentation of racial and ethnic health disparities in Indiana.
- Develop a plan of interventional strategies designed to eliminate racial and ethnic health disparities in Indiana.
- Identify and solidify effective public/private, community-based partnerships to help develop, implement, evaluate, and assess outcomes of the proposed interventional strategies in eliminating racial and ethnic health disparities in Indiana.
- Eliminate disparities in health based on race or ethnicity among Indiana residents such that the "gap effect" for any focus area is less than five percent.

CRITICAL SUCCESS FACTORS

- Community (local, health, corporate, legislative) recognition and perceived importance of racial and ethnic health disparities as a public health issue of state importance.
- Community (local, health, corporate, legislative) agreement with the need to intervene to alter present and future outcomes in health status among Indiana's racial and ethnic minority populations.
- Community (local, health, corporate, legislative) acceptance of the proposed plan as an effective intervention.
- Community (local, health, corporate, legislative) willingness to support interventional strategies as part of an institutional and coordinated effort.

	SUCCESS FACTORS			
Goals	**Recognition and Importance of Disparities**	**Community Agreement with Need to Intervene**	**Community Acceptance of Plan**	**Community Support of Strategies**
Documentation	●	●		
Plan	●	●	●	●
Partnerships	●	●	●	●
No Disparities	●	●	●	●

ISSUES, CONCEPTS, ASSUMPTIONS, AND CAVEATS

There are several key or overarching issues, concepts, assumptions, and caveats that must be addressed, or at least acknowledged, by the Healthy Indiana Minority Health Plan if the goals and objectives of the Plan are to be successfully realized. Among these issues are the following:

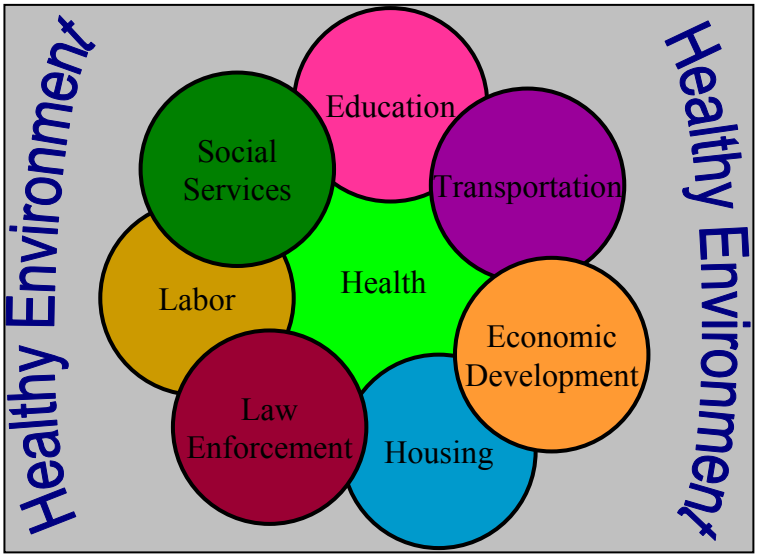
ISSUES

- Health care disparity is a non-partisan issue that should be at the forefront of the Indiana legislative agenda, and the implementation of this Plan must be independent of state and local partisan politics.
- Equity in health care cannot be compromised, and the provision of appropriate and timely access to patient-centered, quality health care services must be ensured.
- Diversity in the workforce can only be accomplished through effective recruitment and retention of underrepresented racial and ethnic minority students in health professions schools and programs.
- A culturally and linguistically competent health care environment – with informed health professionals and caregivers; sufficient levels of appropriate, comprehensive, holistic, fully-funded, sustainable, and culturally/community-based services that foster prevention and quality of life; and relevant materials and programs to educate health professionals and the public – is the foundation for building a successful program to eliminate racial and ethnic health disparities.
- An understanding of the direct and indirect health and economic impact of racial and ethnic health disparities on the education and socioeconomic development of individuals and local communities must not be underestimated, and the cost and burden of ill health must be allocated appropriately across all domains of human interaction to appreciate the full impact of ill health on the education and socioeconomic development of all individuals and within all communities of Indiana.

CONCEPTS

- The elimination or racial and ethnic health disparities and the attainment of health parity can be achieved only through all parties, public and private, working together with a collective consciousness and commitment, sharing economic, technical, and social capital to achieve the highest level of health, well-being and quality of life for all residents of Indiana.
- The public (patients, providers, and payers) must acknowledge the existence and societal importance of racial and ethnic health disparities and become owners of the process for their elimination through an active interest and role in collaborative efforts to eliminate racial and ethnic disparities in health and health care.
- Racial and ethnic health disparities are costly to society and the current economic investment in the elimination of health disparities will generate future dividends in improved health status, reduced rates of illness, disability and excessive mortality, enhanced quality of life, decreased health care spending, and increased opportunity for economic and social development.

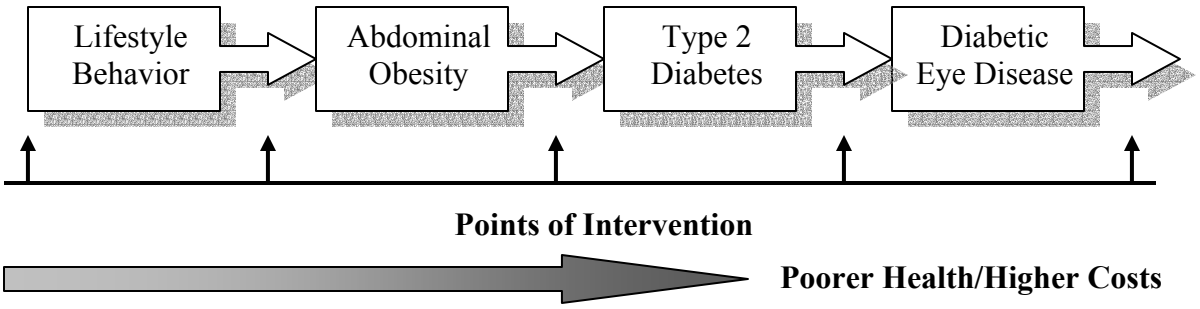
- Comprehensive strategies are necessary to enhance opportunities for financial and geographic access to medically, culturally, and linguistically appropriate, timely, and comprehensive health care services, and improved patient-provider respect, continuity and communication of information regarding aspects of care.
- Health related behavior and practices experienced in early life establish patterns of behavior and practice that continue into adult life.
- The number and representation of racial and ethnic undergraduate, graduate and postgraduate minority students in the health professions must be increased, encouraged and supported through state, professional, and community identified initiatives.
- The local, health, corporate, and legislative communities must actively engage in and support the process of strategy development, implementation and evaluation.
- Health related issues such as behavior, social and physical environments, and related inequalities in socioeconomic status, education, employment, insurance, language, culture, housing, and transportation must be addressed effectively and comprehensively under a multidisciplinary, non-silo, interventional approach and within the broader context of health and its socio-cultural environment.



ASSUMPTIONS

- Planning for the elimination of racial and ethnic health disparities in Indiana is an iterative process, and the current thinking represented by this Plan most likely will be modified and adjusted to accommodate new knowledge and interventions generated by national and local projects, such as the Centers for Disease Control and Prevention (CDC) Racial and Ethnic Approaches to Community Health (REACH 2010), the National Institutes of Health (NIH) National Center on Minority Health and Health Disparities, and the Agency for Healthcare Research and Quality (AHRQ) Excellence Centers to Eliminate Ethnic/Racial Disparities (EXCEED).
- The economic issues and financial constraints affecting state and local governments will increasingly impact all aspects of health care planning and delivery.

- Evidence of change in health status will be incremental and difficult to assess and/or attribute to a specific intervention in the short term.
- Positive behavioral changes in lifestyle and health practices can contribute significantly to improvements in health status with a minimum investment of money and human capital or increased intensity of health care services.



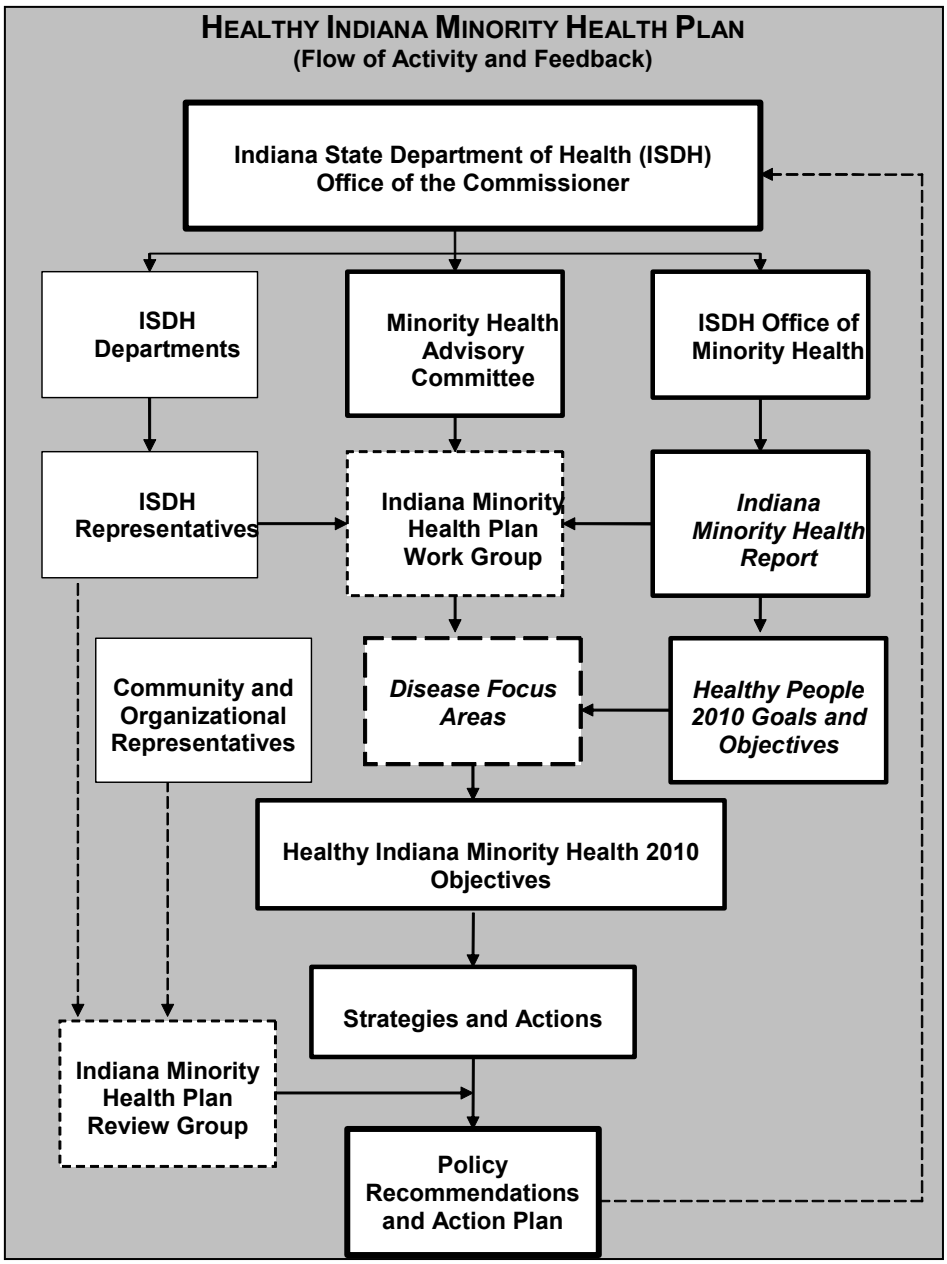
CAVEATS

- As a conscious effort, this Plan focuses on seven disease areas identified by the Indiana Minority Health Advisory Committee as immediate priorities. National and local initiatives have identified other areas of concern beyond the seven dealt with in this Plan. Alzheimer's disease, chemical dependency; child and adult immunizations, homicide, suicide, and unintentional injuries, influenza and pneumonia, kidney disease, liver disease, and septicemia are not without merit as contributors to racial and ethnic health disparities. The exclusion of an area from this Plan does not necessarily weaken its position as a major health concern, nor does it represent an oversight of the Indiana Minority Health Advisory Committee. The Committee decided that the first iteration of this Plan should concentrate on a workable number of disease areas, such as seven, that reflect significant differences in health care delivery and outcomes for the racial and ethnic minority residents of Indiana.
- The development of this Plan assumes a data-driven approach, which is both a strength and a weakness. It is a strength in that the identification of disparities is evidence-based and the proposed remedies are measurable over time. It is a weakness in that state-level, population-based data are limited or absent for certain conditions, events, and/or populations (e.g., prevalence of diabetes among American Indians or Alaska Natives living in Indiana), making it difficult or impossible to assess the severity of the disparity against measured benchmarks or to develop measurable objectives for the elimination of the disparity. The application of nationally derived frequencies of morbidity and mortality to Indiana demographics may provide some indication of the epidemiologic landscape of Indiana for those conditions, events, and/or populations where data are missing or inadequate, but such applications would fall short of providing sufficient evidence for setting reliable objectives that could be measured against realistic Indiana events.
- Inconsistencies and gaps in the state's morbidity and mortality surveillance systems can lead to the underreporting and misreporting of epidemiologic and demographic data and incorrect inferences (or at least unanswered questions) about the differential burdens of

illness among the state's racial and ethnic minority populations. As an example, the population distribution of diabetes prevalence reported among Indiana's racial and ethnic minority populations do not parallel the population distribution of diabetes prevalence reported nationally. This observation may reflect true differences in diabetes prevalence for the populations of Indiana in comparison to the nation at-large, or it may reflect inconsistencies or inaccuracies in the reporting of disease or racial/ethnic data among the populations of Indiana with the consequent problems of validity regarding differential burdens of illness.

APPROACH

The Healthy Indiana Minority Health Plan flows directly from the 2001 Indiana Minority Health Report and *Healthy People 2010*, which was designed to address as one of its two major goals the elimination of health disparities associated with race, ethnicity and socioeconomic status. The Healthy Indiana Minority Health Plan uses the 2001 Indiana Minority Health Report in a data-driven, evidence-based, community-centered, multidisciplinary approach to assess documented gaps in health status and identify critical areas of intervention for Indiana's racial and ethnic minority (American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, Hispanic or Latino) communities. The *Healthy People 2010* objectives that



focus specifically on the areas of disease morbidity and mortality identified as immediate priorities by both the Indiana Minority Health Report and the Indiana Minority Health Advisory Committee are used to establish the Healthy Indiana Minority Health 2010 (HIMH2010) objectives.

After selecting the most relevant HP2010 objectives, based on the Indiana priorities identified by the Indiana Minority Health Report, Indiana-specific, data-driven (HIMH2010) objectives were structured to mirror the nationally-focused HP2010 objectives in those areas where the national targets for the HP2010 objectives exceed the Indiana-specific levels of morbidity or mortality for any racial or ethnic minority population. For example, if the mortality data for the Black or African American population in Indiana reveals that the death rate for heart disease exceeds the target rate specified for the relevant *Healthy People 2010* (HP2010) objective, then a Healthy Indiana Minority Health 2010 (HIMH2010) objective, based on baseline data specific to Indiana, is proposed to help bridge the gap in heart disease for Indiana's Black or African American population. Unsupported objectives, those for which Indiana-specific baseline data were not available, are listed separately as a further emphasis on the need for increased data surveillance.

Indiana baselines and targets could not be determined for many objectives due to a lack of Indiana-specific data.

The Minority Health Advisory Committee reached the opinion that it is important for Indiana to establish state-specific objectives that best reflect the needs and priorities of Indiana in relation to the elimination of racial and ethnic health disparities. The intentional link between the *Healthy People 2010* objectives and the proposed Healthy Indiana Minority Health 2010 objectives, coupled with the use of Indiana-specific data, helps substantiate the rationale for the objectives and targets proposed in the Healthy Indiana Minority Health Plan. In addition to representing state relevant targets, the Indiana objectives will serve also as performance-based indicators of successful activity over the course of the next seven years.

FOCUS AREAS

The 1985 *Report of the Secretary's Task Force on Black & Minority Health* recognized cancer, cardiovascular disease and stroke, chemical dependency, diabetes, homicide and unintentional injuries, and infant mortality as the leading contributors to the health disparity found among racial and ethnic minorities in the U.S. The U.S. Department of Health and Human Services 1998 *Initiative to Eliminate Racial and Ethnic Disparities in Health*, focusing on areas of disparity that affect all racial and ethnic groups, identified the six areas of infant mortality, cardiovascular disease, cancer screening and management, HIV/AIDS, child and adult immunizations, and diabetes.

The 2001 Indiana Minority Health Report identified 15 disease areas – heart disease, cancer, cerebrovascular disease, chronic obstructive pulmonary disease, unintentional injuries and accidents, diabetes, influenza and pneumonia, Alzheimer's disease, kidney disease and nephritis, septicemia, suicide, cirrhosis and chronic liver disease, HIV/AIDS, homicide, and conditions during perinatal period – as the leading causes of morbidity and mortality in Indiana.

The Minority Health Advisory Committee concluded that it could not address all 15 disease areas from the Indiana Minority Health Report in its initial intervention plan. The Committee decided to concentrate on those areas with the greatest "gap effect" in Indiana and, consequently, those producing the greatest amount of unnecessary morbidity and mortality in Indiana's racial and ethnic minority populations. Therefore, the Committee approached the development of the Healthy Indiana Minority Health Plan with emphasis on seven high priority disease focus areas, five of which coincide with those identified previously by the U.S. Department of Health and Human Services in both its 1985 and 1998 reports and initiatives. The following table lists the 7 priority disease focus areas identified by the Indiana Minority Health Advisory Committee and targeted in this initial Plan:

INDIANA MINORITY HEALTH ADVISORY COMMITTEE DISEASE FOCUS AREAS	
Heart Disease (cardiovascular disease)	Diabetes
Cancer (malignant neoplasms)	HIV/AIDS
Stroke (cerebrovascular disease)	Infant Mortality (conditions that originate in the perinatal period)
Asthma (chronic obstructive pulmonary disease/chronic lower respiratory disease)	

INSTITUTIONAL AND COMMUNITY INPUT

The Minority Health Advisory Committee arranged meetings with the ISDH program managers of the focus areas targeted in the Plan to get input on what the relevant programs were doing currently in the area of minority health. Program managers from HIV/STD, Chronic Disease, Nutrition, Indiana Cancer Consortium, Diabetes Control Program, and the Epidemiology Resource Center Infant Mortality were invited to meet with the Committee. The Committee did not meet with a representative from the cardiovascular disease or stroke area because Indiana did not have a formally funded program in either area at the time of the invited meetings. However, the Committee was informed that the State Health Commissioner has assigned cardiovascular disease and stroke to the newly formed Chronic Disease Advisory Council.

Strategic actions and interventions are proposed and tied to the Indiana-specific minority health objectives. The proposed strategies and actions that have the broadest reach and greatest potential for eliminating health disparities and producing healthy outcomes constitute the interventional priorities recommended in the first tier of proposed activity. The Committee was strong in its belief that the community should have the opportunity to provide input into the Plan before it was finalized and reported to the Commissioner. In addition to the members of the Advisory Committee (many of which are representative of the community and community-based organizations), other individuals outside and inside the Indiana State Department of Health and representative of a broad base of knowledge and experience were identified and invited to be part of a review group to comment on the working draft before it was advanced as a consensus document to the Indiana State Health Commissioner.

The Healthy Indiana Minority Health Plan proposes to address the issue of health disparities from the perspective of both general objectives across all areas of morbidity and mortality (workforce diversity, cultural and linguistic competency) and focal objectives linked to the most prevalent conditions affecting Indiana's racial and ethnic minority populations (heart disease, cancer, stroke, asthma, diabetes, HIV/AIDS, and infant mortality). To complement the general and focal objectives, the Plan proposes a series of recommendations under the headings of:

- Public Policy
- ISDH Program Development and/or Expansion
- Health Services
- Health Promotion and Communication Strategies
- Public/Private/Community Partnerships

The Plan's overall approach is to view the solution in terms of structure, process, and outcome by identifying and applying Indiana-relevant objectives, activities, and strategies within existing structures and processes.

STRUCTURE

The structure of the health care system serving the citizens of Indiana is a key element to the design and implementation of the Healthy Indiana Minority Health Plan. The Indiana State Department of Health is the major structural component of the system, and frequently serves as the safety net for those individuals who routinely lack financial and/or geographic access to necessary health care services. Consequently, the Indiana State Department of Health, the ISDH Office of Minority Health, the ISDH Office of Cultural Diversity and Enrichment, and the Indiana Minority Health Advisory Committee are the lead entities in the preparation, development, and implementation of an intervention strategy and plan for eliminating the racial and ethnic disparities in health and health status experienced by Indiana's minority populations.

Related agencies, organizations, and affiliates, including the Interagency State Council on Black and Minority Health, the Indiana Minority Health Coalition, the Indiana Health Care Professional Development Commission, the Chronic Disease Advisory Council, the Indiana Latino Institute, the Indiana Public Health Association, the Indiana University Department of Public Health, and the local health departments complement the structural contributions of ISDH. The U.S. Office of Minority Health and the Office of Minority Health Resource Center are repositories of supportive information, data, and publicly accessible resources. The development and execution of a successful intervention plan (e.g., the Healthy Indiana Minority Health Plan) will require the cooperative, collaborative, and innovative efforts of the Indiana health care system's key structural components.

Indiana Minority Health Coalition

The Indiana Minority Health Coalition (IMHC) is a non-profit organization that was created in 1992 by nine community-based organizations and incorporated in 1994 with a focus on improving the health of Indiana's ethnic and racial minority populations. IMHC deals with a broad range of health issues and promotes and supports its 18 local affiliate county and community coalitions in their efforts to address minority health issues with

advocacy, education, program development, community outreach, service delivery, public relations, research, and leadership. County and community coalitions exist across the state and are established to implement health promotion and disease prevention programming at the local level.

Indiana Health Care Professional Development Commission

The Indiana Health Care Professional Development Commission (HCPDC) was established, under a directive from the Indiana General Assembly, in 1995 by the Indiana State Department of Health to:

- study the current distribution of health care professionals;
- study the future health care professional needs of Indiana;
- formulate long-range planning goals to meet the health care needs of Indiana;
- develop a strategic plan for health care professional development for Indiana;
- ***consider ways of increasing the numbers of minorities in the health care professional workforce*;**
- make recommendations to the General Assembly that will likely achieve a continual flow of health care professionals, appropriately distributed geographically and by specialty and type; and
- submit a report on HCPDC activities to the General Assembly on November 1 of each year.

The Indiana Minority Health Advisory Committee and the Indiana Health Care Professional Development Commission held a joint meeting in association with the Indiana Career and Post-secondary Advancement Center to discuss their mutual interest in and to develop strategies for increasing the numbers of minorities in the health care professional workforce. As a consequence of their meeting and subsequent interactions, the Chair of Minority Health Advisory Committee sent letters on behalf of the Committee to the State Health Commissioner in support of the Health Care Professional Development Commissions' recommendations to: 1) expand eligibility to other health care professions under the Indiana Medical and Nursing Grant Fund statute; 2) continue surveying health care professions in Indiana to generate workforce data on the number, distribution, and specialty of Indiana's health care practitioners; 3) find additional funds to support future HCPDC health care professional surveys so that essential data can continue to be collected; and 4) consider developing a single, unified license renewal/data collection system that cost-effectively gathers information crucial to licensure and health workforce development.

The InMHAC and the HCPDC agreed that a working subcommittee should be created to explore ideas for expanding the pool of racial and ethnic minorities in the health professions and to search for funding to support outreach and recruitment efforts.

Chronic Disease Advisory Council

The Indiana Chronic Disease Advisory Council was created in 2002 by the Indiana State Department of Health to help address the high rate of chronic disease and related mortality in Indiana. The Council is comprised of medical directors of the major health insurance companies, academic experts, non-profit organizations, minority groups, consumer advocates, employers, and representatives of health care provider groups. Diabetes, asthma, heart disease, and obesity represent the primary foci of the Council's efforts, having already developed consensus guidelines for diabetes. Within each of the focus areas to be addressed by the Council there is a need to target minority populations with materials and other means to provide culturally and linguistically appropriate health care education.

Indiana Latino Institute

The Indiana Latino Institute provides quality bilingual-bicultural services related to health, education, and welfare and designed to self-determine and strengthen Latino families living in Indiana. Resources include coalition building and networking with agencies and organizations that provide services to Spanish speaking Latinos, training and technical assistance to build strong organizations, a Latino Resource Center, and a Speakers Bureau.

Indiana Public Health Association

The Indiana Public Health Association (IPHA) was formed in 1946 to unify efforts for advancing public health in the state of Indiana. The mission of IPHA is to promote the health of the people of Indiana through educational programs to improve public health practice, training and research to advance public health, promotion of interest in public health careers, public education about prevention of disease and promotion of wellness, and advocacy for the health of the people through communication with government officials and community leaders.

Indiana University Department of Public Health

The Indiana University (IU) Department of Public Health administers the Master of Public Health (MPH) Program and is housed in the Indiana University School of Medicine. The Department of Public Health is a collaboration of academic units and public health agencies, including 15 IU schools on the Indianapolis and Bloomington campuses, Purdue University, the Indiana State Department of Health, and the Marion County Health Department. The mission of the Indiana University Department of Public Health is to improve the health of the residents of Indiana, the United States and the world through teaching, research, and community practice programs. The Department offers quality degree and non-degree public health education programs to educate and train professionals and agency staff to advance their knowledge and skills in public health.

Local Health Departments

Local health departments, in partnership with local community-based organizations and minority health coalitions, are integral to the implementation of prevention and intervention strategies at the local level. They frequently provide a more grass-roots and community-focused orientation to identifying and meeting the specific health needs of the local area, and may be more adept at galvanizing local resources to support local efforts.

U.S. Office of Minority Health

The U.S. Office of Minority Health (OMH) was created by the U.S. Department of Health and Human Services (HHS) in 1985 as a result of the *Report of Secretary's Task Force on Black and Minority Health*. Under the direction of the Deputy Assistant Secretary for Minority Health, OMH advises the Secretary of Health and Human Services and the Office of Public Health and Science (OPHS) on public health issues affecting American Indians and Alaska Natives, Asian Americans, Native Hawaiians and other Pacific Islanders, Blacks or African Americans, and Hispanics or Latinos. The mission of OMH is to improve the health of racial and ethnic populations through the development of effective health policies and programs that help to eliminate disparities in health. OMH monitors efforts to achieve the goals of *Healthy People 2010* and its focus on eliminating racial and ethnic disparities in health.

The Office of Minority Health Resource Center (OMHRC) serves as a national information and referral service on minority health. The Center collects and distributes information on a variety of topics and provides current minority health data, customized database searches, publications, and information on programs and organizations.

PROCESS

Process considers both the direct and indirect delivery of health care functions and services, including support functions and services, to the citizens and key stakeholders of the Indiana community. Screenings, worksite programs, school-based services, health education and information, surveys, and surveillance systems are examples of direct and indirect functions and services delivered by the health care infrastructure serving Indiana's resident and employer communities. Process also embraces the formation of significant policy recommendations for change and amplification within the nexus of health care service and delivery.

Direct Services

The ability to show progress toward eliminating racial and ethnic disparities in health is conditioned, in part, on the successful, timely, direct, and culturally appropriate delivery of quality health care services to the target populations. Issues of geographic, financial, and temporal access must be addressed in the context of traditional cultures, behaviors, and attitudes. Where appropriate, recommendations will be forwarded with regard to the use of health screenings and health fairs, school and worksite health education and service delivery programs, health information materials, and surveys and other instruments for disease monitoring and surveillance.

Support Services

Programmatic, disease-focused and theme month public service announcements, community-based counseling and education programs, grass-roots health advocacy, and other supportive services help create awareness and discussion of health and health-related issues. Community-based organizations, similar to the Indiana Minority Health Coalition, help provide various types of support services that promote and complement the direct delivery of health care services to priority populations in public and private settings.

Policy Recommendations

Recommendations for new and amended public health policy, legislation and programmatic guidelines will be based on the need to address new and/or expanded areas in public health. The Healthy Indiana Minority Health 2010 objectives provide the platform for setting the direction and formulating recommendations contained in the Healthy Indiana Minority Health Plan. Policy recommendations may address any area of public domain affecting the health of those who live and work in Indiana. For example, changes in ISDH's grant priorities and processes may be necessary to address effectively certain recommended requirements, targets, or expectations regarding data collection and disease surveillance. Alternatively, recommendations may call for the creation of an interagency coordinating entity to oversee the continuing execution of the Healthy Indiana Minority Health Plan and/or to provide future direction and support for activities that help reduce gaps in health and health status for Indiana's racial and ethnic minority populations.

OUTCOME

Outcome reflects the impact of the proposed intervention (the Healthy Indiana Minority Health Plan) on the target population (the racial and ethnic minorities residing and working in Indiana). Within the context of this Plan, outcome will be evaluated through assessment of Indiana's success in achieving the *Healthy People 2010* objectives (HP2010), the proposed Healthy Indiana Minority Health 2010 objectives (HIMH2010), and evidence of an improved health status among the racial and ethnic minority populations of Indiana. The Indiana Minority Health Advisory Committee proposes that a biennial report focusing on the state of progress made by Indiana toward achieving the intended outcomes of the Healthy Indiana Minority Health Plan be submitted to the Indiana Legislature and Governor.

Approach/Meet the *Healthy People 2010* Objectives

Attainment or movement towards the HP2010 objectives will serve as a general indicator of the intermediate and long-term progress or success of the Healthy Indiana Minority Health Plan in addressing the gaps in health and health status among Indiana's minority populations.

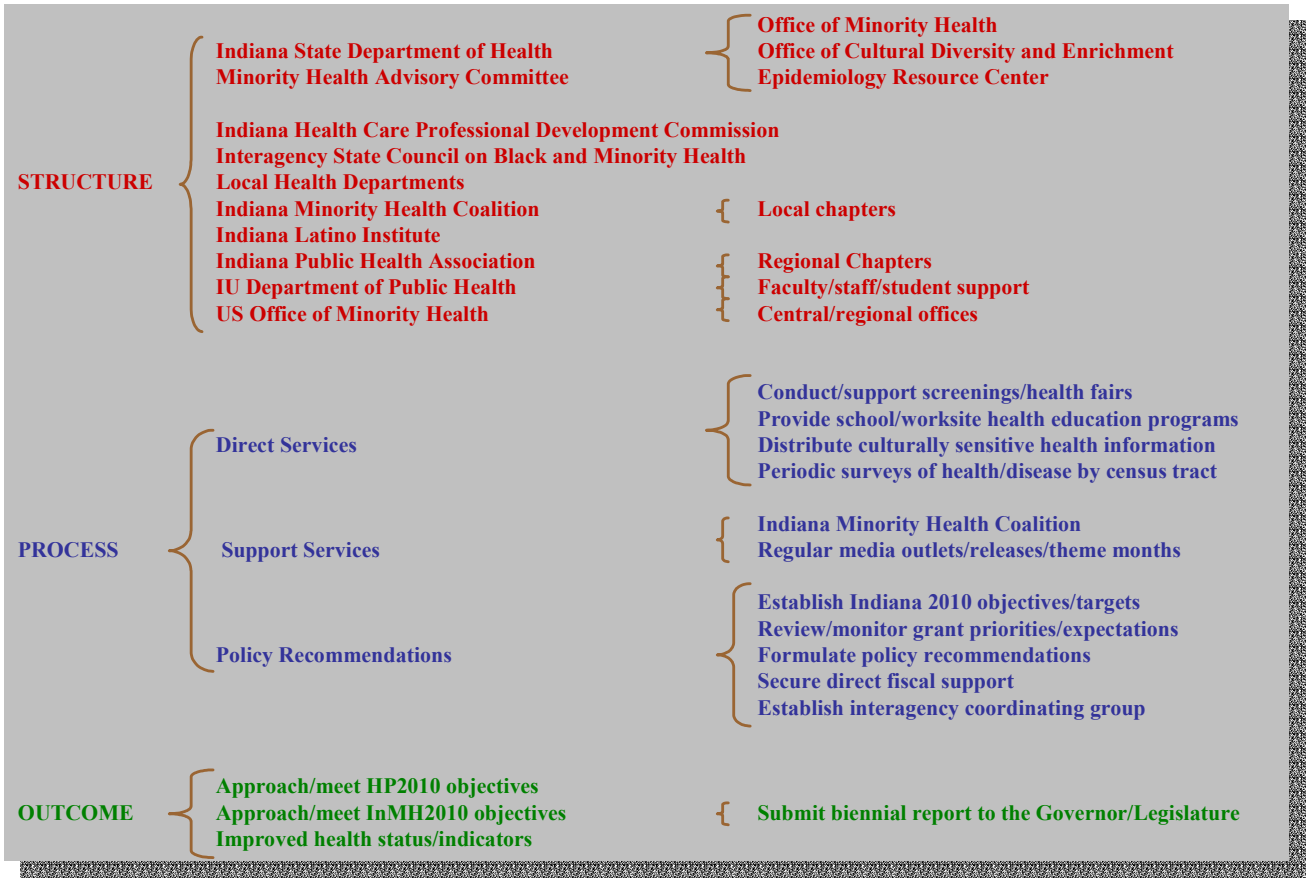
Approach/Meet the Healthy Indiana Minority Health 2010 Objectives

Attainment or movement towards the Healthy Indiana Minority Health 2010 objectives will serve as an Indiana-specific indicator of the intermediate and long-term progress or

success of the Healthy Indiana Minority Health Plan in addressing the gaps in health and health status among Indiana's minority populations. Similarly, movement towards attainment of a "gap effect" of less than five percent for any focus area would be a positive indication of successful progress. A status report with updated recommendations, as necessary, will be submitted biennially to the health leaders (primarily the chairs and members of the Senate and House health committees) in the Indiana Legislature and to the Governor.

Improved Health Status/Indicators

Documented improvement in the health status and/or health indicators of Indiana's minority populations will provide evidence of intermediate and long-term progress or success of the Healthy Indiana Minority Health Plan in addressing the gaps in health and health status among Indiana's minority populations. A status report with updated recommendations, as necessary, will be submitted biennially to the health leaders (primarily the chairs and members of the Senate and House health committees) in the Indiana Legislature and to the Governor.



GENERAL OBJECTIVES

WORKFORCE DIVERSITY

RATIONALE

Diversity and competency of the workforce are vital elements to the elimination of racial and ethnic disparities in health. However, diversity in the workforce does not necessarily imply competency in the workforce's ability to respond appropriately to the cultural and linguistic differences existent within culturally and linguistically diverse populations.

Cultural differences between providers and patients can lead to misunderstanding, misrepresentation, distrust, and disrespect in the delivery and receipt of health care services. The availability of a racially and ethnically diverse health care workforce within diverse communities enhances the potential for establishing cultural and linguistic bonds that foster consistent, closer, comfortable, and communicative relationships and interaction between providers and patients.

Racially and ethnically diverse providers are better suited to promote higher levels of cultural understanding, more effective communication, and shared and informed decision making within racial and ethnic minority communities. Racial and ethnic minority providers also are more likely to locate and practice in racial and ethnic minority communities and less likely to allow (directly or indirectly, consciously or subconsciously) racial bias and stereotyping to affect their decision making, therapeutic protocols, and compliance with recommended practice guidelines.

Like the nation, Indiana is challenged to be responsive to the increasing diversity of its population . . . Chief among [existing barriers to minority recruitment and retention in the health professions] are the lack of adequate preprofessional educational preparation for a health career; a shortage of mentors and role models for minority preprofessional and professional students; and the lack of support systems and educational programs for minority health care professional students during their professional education . . . Through partnerships and collaboration among the health care professions, the state's educational community, health care providers, public and private insurers, business, labor, consumers and state agencies, Indiana can work to devise effective strategies to overcome barriers to minority recruitment and retention.

Indiana Health Care Professional Development Commission Annual Report 1995

The National Center for Health Workforce Information and Analysis within the Bureau of Health Professions of the Health Resources and Services Administration, DHHS, provide data that can be used to describe the diversity in the Indiana workforce. The following chart is based on that data.

PROFESSIONAL WORKFORCE	PERCENT OF INDIANA WORKFORCE BY RACE OR ETHNICITY, 1996-99				
	American Indian or Alaska Native	Asian or Pacific Islander	Black or African American	Hispanic or Latino	White
Allied Health Professionals					
Physical Therapists	0.3	8.2	4.8	4.7	82.0
Occupational Therapists	2.0	0.0	6.0	2.0	89.0
Respiratory Therapists	0.0	7.0	17.0	2.0	74.0
Speech-Language Pathologists and Audiologists	0.0	2.0	1.0	4.0	93.0
Medical Records Technicians	1.0	7.0	16.0	1.0	74.0
Laboratory Technologists	1.0	8.0	19.0	5.0	67.0
Radiologic Technologists	0.0	2.0	10.0	4.0	84.0
Registered Nurses	0.3	2.0	2.8	0.7	93.9
Physicians	0.0	11.0	3.0	2.0	84.0
Dentists	0.0	5.0	2.0	4.0	89.0
Pharmacists	0.0	14.0	6.0	3.0	77.0
Optometrists	0.0	10.0	4.0	3.0	83.0
Podiatrists	0.0	0.0	5.0	8.0	87.0

Not evident from the above chart is the fact that Indiana has a public health workforce equivalency of 46 public health practitioners per 100,000 Indiana residents, compared to public health workforce averages of 76 practitioners per 100,000 population for the U.S. DHHS V (Midwest region) and 138 per 100,000 population nationally. The actually and comparatively small workforce of public health practitioners in Indiana exacerbates the problem and complicates the implementation of solutions to the elimination of health disparities among Indiana's racial and ethnic populations.

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – WORKFORCE DIVERSITY

Baseline data for the Workforce Diversity objectives are derived from the December 2000 HRSA State Health Workforce Profiles for Indiana developed for the Bureau of Health Professions National Center for Health Workforce Information and Analysis by the Center

for Workforce Studies at the State University of New York School of Public Health. Indiana has programs of higher education in allied health, nursing, medicine, dentistry, pharmacy, and optometry. Academic programs leading to degrees in chiropractic or podiatry do not exist in Indiana. The following chart, based partially on the HRSA Indiana Profile, shows the percent of degrees awarded to racial and ethnic minority graduates in allied health, nursing, medicine, dentistry, and pharmacy in 1996-97. The degree data for optometry and public health were obtained directly from the Indiana degree-granting programs (the Indiana University School of Optometry and the Department of Public Health in the Indiana University School of Medicine) for the years of 2001 and 2002, respectively.

PROFESSIONAL WORKFORCE	PERCENT OF DEGREE RECIPIENTS IN INDIANA BY RACE OR ETHNICITY, 1996-97*				
	American Indian or Alaska Native	Asian or Pacific Islander	Black or African American	Hispanic or Latino	White
Allied Health					
Physical Therapy	0.0	3.0	0.0	0.0	97.0
Occupational Therapy	0.0	0.7	2.7	0.7	95.9
Respiratory Therapy	0.0	0.0	8.9	2.4	88.6
Speech-Language Pathology and Audiology	0.0	0.4	2.1	0.4	97.2
Medical Records Technicians	0.0	0.0	11.0	4.1	84.9
Laboratory Technology	0.0	1.9	5.7	5.7	86.8
Radiologic Technology	0.5	1.0	1.6	0.5	96.3
Nursing	0.3	0.6	3.5	1.5	94.1
Medicine	0.4	7.8	3.1	1.2	87.5
Dentistry	0.0	12.0	2.7	2.7	82.7
Pharmacy	0.0	5.0	1.0	2.0	92.0
Optometry	1.3	5.3	1.3	1.3	89.5
Public Health	0.0	6.0	19.0	0.0	75.0

*Optometry – data are for 2001
Public Health – data are for 2002

Healthy People 2010 provides 1 objective and 20 sub-objectives specific to workforce diversity. The relevant objective and sub-objectives are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***.

Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

WORKFORCE DIVERSITY OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
WFD-1 **HP2010 Ref: 1-8a-d**	**In allied health, increase the proportion of all degrees awarded to:** **1. American Indians or Alaska Natives to 0.6%.** **2. Asians or Pacific Islanders to 1.2%.** **3. Blacks or African Americans to 8.8%;** **4. Hispanics or Latinos to 3.5%.**	***Refer to above chart – Percent of Degree Recipients in Indiana by Race or Ethnicity***
WFD-2 **HP2010 Ref: 1-8e-h**	**In nursing, increase the proportion of all degrees awarded to:** **1. American Indians or Alaska Natives from 0.3% (1996-97) to 0.6%.** **2. Asians or Pacific Islanders from 0.6% (1996-97) to 1.2%.** **3. Blacks or African Americans from 3.5% (1996-97) to 8.8%;** **4. Hispanics or Latinos from 1.5% (1996-97) to 3.5%.**	***Refer to above chart – Percent of Degree Recipients in Indiana by Race or Ethnicity***
WFD-3 **HP2010 Ref: 1-8i-l**	**In medicine, increase the proportion of all degrees awarded to:** **1. American Indians or Alaska Natives from 0.4% (1996-97) to 0.6%.** **2. Blacks or African Americans from 3.1% (1996-97) to 8.8%.** **3. Hispanics or Latinos from 1.2% (1996-97) to 3.5%.**	***Refer to above chart – Percent of Degree Recipients in Indiana by Race or Ethnicity***
WFD-4 **HP2010 Ref: 1-8m-p**	**In dentistry, increase the proportion of all degrees awarded to:** **1. American Indians or Alaska Natives from 0.0% (1996-97) to 0.6%.** **2. Blacks or African Americans from 2.7% (1996-97) to 8.8%.** **3. Hispanics or Latinos from 2.7% (1996-97) to 3.5%.**	***Refer to above chart – Percent of Degree Recipients in Indiana by Race or Ethnicity***
WFD-5	**In pharmacy, increase the proportion of all degrees awarded to:**	***Refer to above chart – Percent of Degree Recipients in Indiana by Race or***

HP2010 Ref: 1-8q-t	**1. American Indians or Alaska Natives from 0.0% (1996-97) to 0.6%.** **2. Blacks or African Americans from 1.0% (1996-97) to 8.8%.** **3. Hispanics or Latinos from 2.0% (1996-97) to 3.5%.**	***Ethnicity***
WFD-6 **HP2010 Ref: 1-8a-d**	**In optometry, increase the proportion of all degrees awarded to:** **1. American Indians or Alaska Natives from 1.3% (2001) to 0.6% (*objective currently met, but tenuous*).** **2. Blacks or African Americans from 1.3% (2001) to 8.8%.** **3. Hispanics or Latinos from 1.3% (2001) to 3.5%.**	***Refer to above chart – Percent of Degree Recipients in Indiana by Race or Ethnicity***
WFD-7 **HP2010 Ref: 1-8a-d**	**In public health, increase the proportion of all degrees awarded to:** **1. American Indians or Alaska Natives from 0.0% (2002) to 0.6%.** **2. Hispanics or Latinos from 0.0% (2002) to 3.5%.**	***Refer to above chart – Percent of Degree Recipients in Indiana by Race or Ethnicity***
WFD-S1.1 – WFD-S7.1	*Develop and implement "best practice" minority-specific programs to promote careers in allied health, nursing, medicine, dentistry, pharmacy, optometry, and public health with realistic role models to American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, and Hispanic or Latino K-12 students living in minority communities.*	
WFD-S1.2 – WFD-S7.2	*Develop academic partnerships and pipelines with minority-serving institutions, health professions associations, and student organizations to facilitate the recruitment of American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, and Hispanic or Latino students into allied health, nursing, medicine, dentistry, pharmacy, optometry, and public health.*	
WFD-S1.3 – WFD-S7.3	*Identify, initiate, develop, and publicize financial assistance programs specifically designed to support the education and training of American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, and Hispanic or Latino students in allied health, nursing, medicine, dentistry, pharmacy, optometry, and public health.*	
WFD-S1.4 – WFD-S7.4	*Develop and expand loan forgiveness programs for American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, and Hispanic or Latino graduates who practice allied health, nursing, medicine, dentistry, pharmacy, optometry, or public health in underserved minority communities.*	
WFD-S1.5 – WFD-S7.5	*Develop and expand opportunities for increasing cultural and linguistic competency among administrators, faculty, and staff in allied health, nursing, medicine, dentistry, pharmacy, optometry, and public health.*	

WFD-S1.6 – WFD-S7.6	*Develop, implement, and expand initiatives to increase the number and proportion of American Indian or Alaska Native, Asian or Pacific Islander, Black or African American, and Hispanic or Latino didactic and clinical faculty in allied health, nursing, medicine, dentistry, pharmacy, optometry, and public health.*

CULTURAL AND LINGUISTIC COMPETENCE

RATIONALE

Racial and ethnic minority communities tend to have smaller numbers of health care practitioners (particularly those who look like them and talk like them) located and practicing in their communities. The lack of identifiably appropriate and relevant health care providers and services in racial and ethnic minority communities can create provider and/or patient related barriers that potentially hamper the community's sense of having routine and consistent access to a usual source of health care, especially primary preventive care that is culturally appropriate, competent, and timely in its responses to community health care needs. Such problems of access are further compounded for populations whose primary language is not English.

Cultural beliefs, values, attitudes, experiences, and practices across diverse populations help form and influence variations in health understanding and behavior, and potentially impact interaction and communication between patient and provider.

The U.S. Department of Health and Human Services defines cultural and linguistic competence as "the ability of health care providers and health care organizations to understand and respond effectively to the cultural and linguistic needs brought by the patient to the health care encounter."

Cultural competence requires that a person possesses the complement of academic and personal skills necessary for understanding and appreciating the cultural differences that exist between diverse groups. Cultural incompetence or a lack of understanding and appreciation of cultural differences in the delivery of health care services can lead to misunderstandings and misinterpretations of clinical actions, diagnoses, and treatment recommendations and thereby adversely affect the provider-patient interaction, the quality of the health care outcomes, and the degree of patient satisfaction with the health care encounter and/or system. Cultural competence allows health care providers to obtain necessary, specific, complete, and accurate information to make appropriate diagnoses; facilitates the development of treatment plans that are more readily followed by the patient and supported by the family; reduces delays in seeking care and allows for more appropriate use of health services; enhances overall communication and clinical interaction between providers and patients; and fosters compatibility between western health practices and traditional cultural health practices.

Linguistic competence facilitates open and clear communication between providers and patients. Health care providers and practice facilities without appropriate translation and interpreter services are handicapped in their ability to provide linguistically and, therefore clinically, competent care to populations of patients whose primary language is not English and in situations where health, language proficiency, and literacy are compromised. A lack of linguistic competence can

Census 2000 indicates that a language other than English is spoken at home by 6.4 percent of the Indiana population.

create difficulties in doctor-patient communication, which in turn can create misunderstanding in the interpretation of symptoms, illnesses, questions, and instructions and possibly lead to problems in the selection and efficacy of treatment regimens. Such circumstances further exacerbate the difficulties of access to care and the subsequent presentation of disparities in the delivery and quality of care for Indiana's linguistically vulnerable populations.

Imbedded throughout this Plan is the understanding that cultural and linguistic competency is paramount to the effective implementation of interventional strategies that target the diversity of racial and ethnic populations and those cultural and language issues impacting and impacted by health disparities.

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – CULTURAL AND LINGUISTIC COMPETENCE

Healthy People 2010 provides two objectives specific to cultural and linguistic competence. The relevant objectives are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***. Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

CULTURAL AND LINGUISTIC COMPETENCE OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
CLC-1 **HP2010 Ref: 11-6**	**Improve data monitoring and evaluation of programs and efforts to enhance cultural competency in health care.**	
CLC-S1.1	*Develop and implement mechanisms to effectively evaluate state funded programs and monitor program data submitted by state funded contractors to ensure they are serving the target population they committed to serve as specified in their grant proposal.*	
CLC-S1.2	*Initiate and maintain research of health care trend data to ensure that targeted patients are utilizing health care services appropriately, effectively, and efficiently.*	
CLC-2 **HP2010 Ref: 11-6**	**Expand education outreach efforts to promote culturally competent health care systems.**	
CLC-S2.1	*Expand opportunities for health care organizations to provide cultural competency training through ongoing workshops and self-assessments.*	
CLC-S2.2	*Expand opportunities to educate patients on how to communicate effectively with health care providers about their cultural beliefs so that providers will be better prepared and able to provide quality health care services.*	

CLC-3 **HP2010 Ref: 11-6**	**Review and analyze organizational policies in an effort to promote cultural competency.**	
CLC-S3.1	*Advocate the need for governmental agencies to prepare and disseminate relevant socio-cultural statements when making, implementing, and evaluating health care policy.*	
CLC-S3.2	*Expand opportunities to assist health care professionals in understanding key policies and operational issues related to cultural and linguistic competencies.*	
CLC-S3.3	*Design and implement policies and procedures of health care service delivery to ensure their clinical relevance and applicability to diverse patient populations.*	
CLC-4 **HP2010 Ref: 11-6**	**Promote a culturally and linguistically competent system of health care that acknowledges and incorporates all levels of importance of culture and language, the cultural strengths associated with people and communities, and the assessment of cross-cultural relations.**	
CLC-S4.1	*Develop written guidelines for cultural and linguistic competence and make them readily accessible to all health care professionals within the organization.*	
CLC-5 **HP2010 Ref: 11-6**	**Promote better understanding of strategies on how to serve diverse populations.**	
CLC-S5.1	*Gain knowledge about strategies and tools that can be used to enhance cultural competence through organizational self-assessments, cultural workshops, written materials, and participation in community-based cultural activities.*	
CLC-S5.2	*Promote and support research in minority health as a high priority within the state's health professions schools.*	
CLC-6 **HP2010 Ref: 11-6**	**Reduce access to care barriers that foster racial and ethnic disparities in health.**	
CLC-S6.1	*Increase the availability of culturally appropriate and linguistically competent health care services in racial and ethnic minority communities.*	
CLC-S6.2	*Improve the level of patient trust in health care providers by increasing communication that is conducive to effective diagnosis and treatment, continuity of care, and adherence to treatment regimens.*	
CLC-7 **HP2010 Ref: 11-6**	**Reduce organizational barriers that impact leadership and workforce and foster racial and ethnic disparities in health.**	

CLC-S7.1	*Recruit, educate, train, and retain minority health care providers and increase their representation and roles in providing health care services and leadership to underserved and targeted populations.*	
CLC-S7.2	*Train all health care professionals to be culturally competent and aware of differences in racial, ethnic, and cultural beliefs.*	
CLC-8 **HP2010 Ref: 11-6**	**Reduce systemic barriers that impact structure, logistics, and processes of care and foster racial and ethnic disparities in health.**	
CLC-S8.1	*Improve compliance of health care providers in following clinical care guidelines provided by nationally recognized health promotion and disease prevention organizations that specialize in the health care of minority patients.*	
CLC-S8.2	*Increase overall life expectancy of minority populations by improving the quantity and quality of health care at every stage of life.*	
CLC-S8.3	*Increase availability of interpretation and translation services, telephone services, transportation services, and culturally specific health education materials for communities with high concentration of minority residents.*	
CLC-9 **HP2010 Ref: 11-6**	**Reduce provider-based barriers that impact health care encounters, provider-patient communication and foster racial and ethnic disparities in health.**	
CLC-S9.1	*Increase the level of patient trust in health care providers, improve provider-patient communication that is conducive to effective diagnosis and treatment, continuity of care, and adherence to treatment regimens, and produce more positive health outcomes by increasing health care providers' respect for patients' racial, ethnic and cultural background and their understanding of its relevance to the delivery of health care services.*	
CLC-S9.2	*Increase patient satisfaction and build positive relationships between satisfaction, adherence to care recommendations, and health care outcomes by expanding opportunities for health care providers to gain training in and understanding of socio-cultural variations in health beliefs and behaviors.*	

FOCAL OBJECTIVES – HEAL THE GAP

HEART DISEASE

RATIONALE

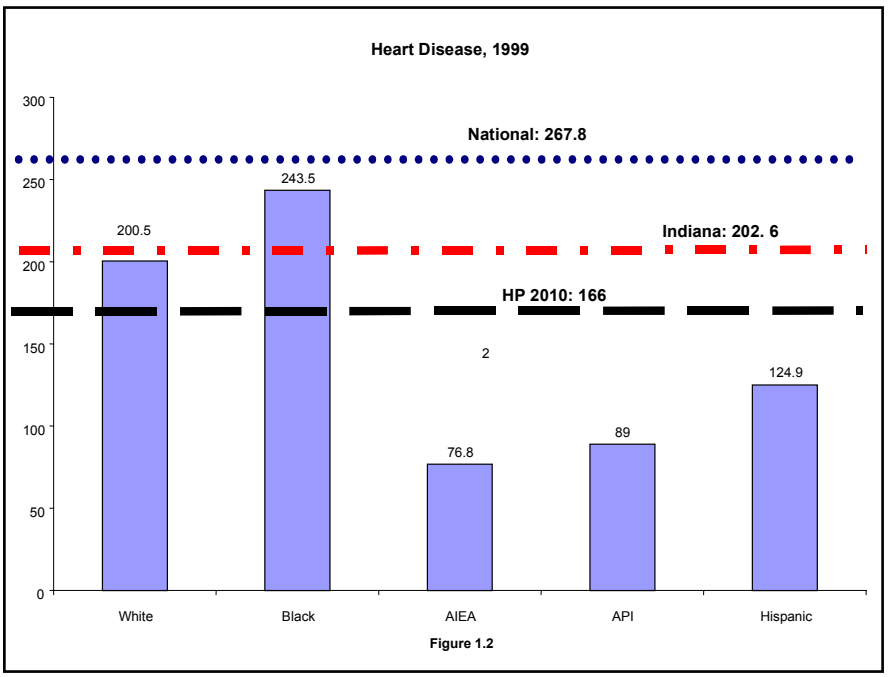
Heart disease is the ***leading cause of death*** for every race, ethnic group, and gender in the United States. The pattern is the same in Indiana, except in the Asian or Pacific Islander population. The American Heart Association has identified increasing age, gender, and heredity as non-lifestyle risk factors for coronary heart disease (CHD). Lifestyle factors or habits include smoking, high cholesterol, high blood pressure, physical inactivity, and obesity.

African American death toll in 2000

1,115

Indiana deaths caused by heart disease

According to the American Heart Association, national death rates for coronary heart disease in 1999 were 272.6 per 100,000 for Black or African American males, 249.4 for White males, 192.5 for Black or African American females, and 152.5 for White females. CHD death rates were not as high for Hispanics or Latinos at 138.4 per 100,000, American Indians or Alaska Natives at 123.9, or Asians or Pacific Islanders at 115.7. Statistically, men generally have higher death rates for heart disease. Among racial or ethnic minorities, Blacks or African Americans rank the highest for heart disease for both males and females.



Rates per 100,000 population (columns reflect Indiana data)

High blood pressure is known as the "silent killer" and remains a major risk factor for coronary heart disease.

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – HEART DISEASE

Healthy People 2010 provides 6 objectives specific to heart disease and another 8 specific to blood pressure and cholesterol. Of those 14 objectives, the most relevant to the purpose and objectives of the Healthy Indiana Minority Health Plan are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***. Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

HEART DISEASE OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
CVD-1 **HP2010 Ref: 12-1**	**Reduce coronary heart disease deaths among Indiana's Black or African American population from 243.5 coronary heart disease deaths per 100,000 Black or African American persons (2000) to 170.5 deaths per 100,000 Black or African American persons (reduce to InMHAC target of 30% improvement).**	• **Total: 203.6 per 100,000** • **American Indian or Alaska Native: 66.7 per 100,000** • **Asian or Pacific Islander: 99.4 per 100,000** • **Black or African American: 243.5 per 100,000** • **Hispanic or Latino: 173.2 per 100,000** • **White: 203.1 per 100,000**
CVD-2 **HP2010 Ref: 12-1**	**Reduce coronary heart disease deaths among Indiana's Hispanic or Latino population from 173.2 coronary heart disease deaths per 100,000 Hispanic or Latino persons (2000) to 161.1 deaths per 100,000 Hispanic or Latino persons (reduce to InMHAC target of 7% improvement).**	• **Total: 203.6 per 100,000** • **American Indian or Alaska Native: 66.7 per 100,000** • **Asian or Pacific Islander: 99.4 per 100,000** • **Black or African American: 243.5 per 100,000** • **Hispanic or Latino: 173.2 per 100,000** • **White: 203.1 per 100,000**
CVD-S1.1 – CVD-S2.1	*Increase opportunities to educate Black or African American and Hispanic or Latino adolescents and adults about the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911.*	
CVD-S1.2 – CVD-S2.2	*Increase opportunities to educate Black or African American and Hispanic or Latino adolescents and adults about the need to call 911 and administer cardiopulmonary resuscitation (CPR) when they witness an out-or-hospital cardiac arrest.*	
CVD-S1.3 – CVD-S2.3	*Increase opportunities to educate Black or African American and Hispanic or Latino adolescents and adults on how to locate the necessary equipment and provide the first therapeutic electrical shock within 6 minutes after collapse when witnessing out-or-*	

	hospital cardiac arrest.	
CVD-3 **HP2010 Ref: 12-9** **Cross Ref: STR-3**	**Reduce the proportion of adults among Indiana's Black or African American population with high blood pressure from 35.6% of Black or African American adults aged 20 years and older (2001) to 16.0% (reduce to HP2010 target).**	• **Total: 25.7%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 35.6%** • **Hispanic or Latino: 15.8%** • **White: 25.2%**
CVD-S3.1 Cross Ref: *STR-S3.1*	*Work with the Office of Medicaid/Medicare Planning to do population sampling and use Geographic Information Systems (GIS) to locate, identify, and target Black or African American communities with high incidence and prevalence of high blood pressure.*	
CVD-S3.2 Cross Ref: *STR-S3.2*	*Increase opportunities to educate Black or African American adults about the dangers of high blood pressure and its complications (e.g., damage to the heart, blood vessels, brain, kidneys, and eyes), and the behaviors that the increase risk for high blood pressure (e.g., cigarette smoking, obesity, physical inactivity, high dietary fat and sodium, excessive alcohol consumption, etc.).*	
CVD-S3.3 Cross Ref: *STR-S3.3*	*Develop educational campaigns and clinical interventions that promote and support therapeutic lifestyle changes and heart healthy behavior (e.g., smoking cessation; high and low intensity exercise such as walking, jogging, basketball, house/yard work.; weight reduction; reduced intake of saturated fats and cholesterol as in the DASH [Dietary Approaches to Stop Hypertension] eating plan; etc.) among people with high blood pressure.*	
CVD-S3.4 Cross Ref: *STR-S3.4*	*Promote among Black or African American populations, as an adjunct to the need for regular follow-up visits and therapy, the methods of monitoring blood pressure at home (e.g., self-measurement) with the rationale that home monitoring improves therapeutic compliance and response.*	
CVD-S3.5 Cross Ref: *CVD-S4.1 – CVD-S7.1 STR-S3.5 STR-S4.1 – STR-S7.1*	*Promote among Indiana's health care professionals the use of the Indiana Consensus Guidelines for cardiovascular disease.*	
CVD-S3.6 Cross Ref: *STR-S3.6*	*Promote among Indiana's health care professionals the use of the guidelines, recommendations, and protocols for high blood pressure measurement and management advanced by the National High Blood Pressure Education Program and the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (e.g., JNC VI).*	
CVD-S3.7 Cross Ref: *STR-S3.7*	*Promote among Indiana's health care professionals the use of the consensus recommendations of the Hypertension in African Americans Working Group of the International Society on Hypertension in Blacks.*	
CVD-S3.8	*Promote among Indiana's health care professionals the recommendations and*	

Cross Ref: *STR-S3.8* *DIA-S1.6 – DIA-S3.6*	*protocols for assessing and managing overweight and obesity advanced by the Obesity Education Initiative of the National Heart, Lung, and Blood Institute, the Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, and the Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults.*	
CVD-S3.9 Cross Ref: *STR-S3.9* *DIA-S1.8 – DIA-S3.8*	*Promote among Indiana's health care professionals the recommendations on intensive behavioral dietary counseling for adult patients with high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease, such as high blood pressure and obesity, as provided in the Guide to Clinical Preventive Services (Counseling to Promote a Healthy Diet) advanced by the U.S. Preventive Services Task Force.*	
CVD-S3.10 Cross Ref: *STR-S3.10* *DIA-S1.12 – DIA-S3.12*	*Promote among racial and ethnic minority communities the availability and importance of enrolling in Chronic Disease Self-Management courses offered through the Indiana Minority Health Coalition.*	
CVD-4 **HP2010 Ref: 12-14** **Cross Ref: STR-4**	**Reduce the proportion of adults among Indiana's Black or African American population with high total blood cholesterol levels from 20.5% of Black or African adults aged 20 years and older (2001) to 17.0% (reduce to HP2010 target).**	• **Total: 29.9%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 20.5%** • **Hispanic or Latino: 28.4%** • **White: 30.8%**
CVD-5 **HP2010 Ref: 12-14** **Cross Ref: STR-5**	**Reduce the proportion of adults among Indiana's Hispanic or Latino population with high total blood cholesterol levels from 28.4% of Hispanic or Latino adults aged 20 years and older (2001) to 17.0% (reduce to HP2010 target).**	• **Total: 29.9%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 20.5%** • **Hispanic or Latino: 28.4%** • **White: 30.8%**
CVD-6 **HP2010 Ref: 12-15** **Cross Ref: STR-6**	**Increase the proportion of adults among Indiana's Black or African American population who have had their blood cholesterol checked within the preceding 5 years from 74.8% of Black or African American adults aged 18 years and older (2001) to 85.0% (increase to InMHAC target).**	• **Total: 69.9%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 74.8%** • **Hispanic or Latino: 53.1%** • **White: 70.2%**
CVD-7 **HP2010 Ref: 12-15** **Cross Ref: STR-7**	**Increase the proportion of adults among Indiana's Hispanic or Latino population who have had their blood cholesterol checked within the preceding 5 years from 53.1% of Hispanic or Latino adults aged 18 years and older (2001) to 85.0%**	• **Total: 69.9%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 74.8%** • **Hispanic or Latino: 53.1%**

	(increase to InMHAC target).	• **White: 70.2%**
CVD-S4.1 – CVD-S7.1 Cross Ref: *CVD-S3.5 STR-S3.5 STR-S4.1 – STR-S7.1*	*Promote among Indiana's health care professionals the use of the Indiana Consensus Guidelines for cardiovascular disease.*	
CVD-S4.2 – CVD-S7.2 Cross Ref: *STR-S4.2 – STR-S7.2*	*Promote among Indiana's health care professionals the use of the guidelines, recommendations, and protocols for cholesterol testing and management advanced by the National Cholesterol Education Program and the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel [ATP] III).*	

OBJECTIVES UNSUPPORTED BY INDIANA-SPECIFIC BASELINE DATA – HEART DISEASE

HEART DISEASE UNSUPPORTED OBJECTIVES AND *POTENTIAL STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE NOT AVAILABLE**
CVD-U1 HP2010 Ref: 12-10 Cross Ref: STR-U1	Increase the proportion of adults among Indiana's Black or African American population with high blood pressure whose blood pressure is under control from X% of Black or African American adults aged 18 years and older with high blood pressure (2000) to 50% (increase to HP2010 target).	• Total: X% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: X%
CVD-U2 HP2010 Ref: 12-11 Cross Ref: STR-U2	Increase the proportion of adults among Indiana's Black or African American population with high blood pressure who are taking action (for example, smoking cessation, losing weight, increasing physical activity, reducing sodium intake, and compliance with therapeutic regimens) to help control their blood pressure from X% of Black or African American adults aged 18 years and older with high blood pressure (2000) to 95% (increase to HP2010 target).	• Total: X% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: X%
CVD-U3 HP2010 Ref: 12-12 Cross Ref: STR-U3	Increase the proportion of adults among Indiana's Black or African American population who have had their blood pressure measured within the preceding year and can state whether their blood pressure was normal or high from X% of Black or African American adults aged	• Total: X% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X%

	18 years and older (2000) to 95% (increase to HP2010 target).	• White: X%
	Potential Strategies: CVD-S3.1 – CVD-S3.10	
CVD-U4 HP2010 Ref: 12-13 Cross Ref: STR-U4	Reduce the mean total blood cholesterol levels of adults among Indiana's racial and ethnic populations from X mg/dL for racial and ethnic minority adults aged 20 years and older (2000) to 199 mg/dL (reduce to HP2010 target).	• Total: X mg/dL • American Indian or Alaska Native: X mg/dL • Asian or Pacific Islander: X mg/dL • Black or African American: X mg/dL • Hispanic or Latino: X mg/dL • White: X mg/dL
	Potential Strategies: CVD-S4.1 – CVD-S7.1 *CVD-S4.2 – CVD-S7.2*	

CANCER

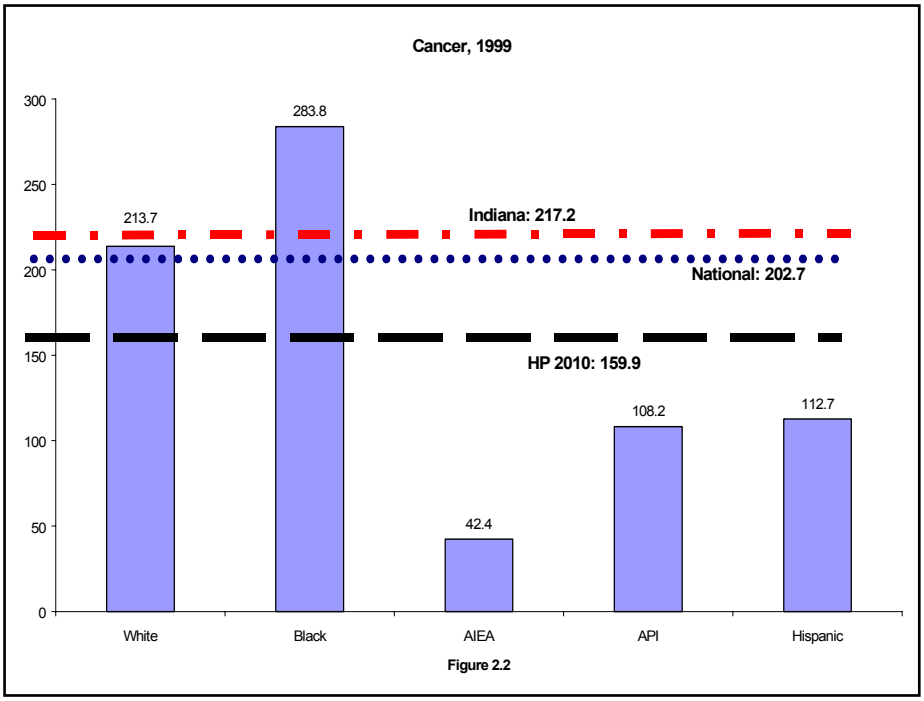
RATIONALE

Cancer is the ***second leading cause of death*** in the U.S., with 549,838 deaths in 1999.

Cancer rates vary among and within different racial and ethnic groups. The highest age-adjusted mortality rate occurs in Black or African American women, followed by White women.

Top 5 Cancer Sites & New Cases Indiana, 1999	
Lung:	**4,300**
Breast (female):	**3,900**
Prostate:	**3,700**
Colorectal:	**3,000**
Uterine Cervix:	**300**

The top three cancers for White and Black or African American females in 1999 were breast, lung and bronchus, and colon and rectum. Compared to other racial and ethnic groups, Black or African American women are generally diagnosed with breast cancer in the later, less treatable stages of the disease. Asian or Pacific Islander women have higher incidences of breast and cervical cancer than any other cancer. According to CDC, early detection of breast and cervical cancers through timely and routine screening could save lives, but women who have less than a high school education, are older, live below the poverty level, or are members of certain racial and ethnic minority groups tend to underuse mammograms and Pap tests.



Rates per 100,000 population (columns reflect Indiana data)

Black or African American males have a 35 percent higher cancer rate than White males. The top three cancers in the U.S. in 1999 in White and Black or African American males were prostate, lung and bronchus, and colon and rectum.

CDC reports that cancer deaths attributable to smoking (lung, trachea, bronchus) were higher nationally among American Indian or Alaska Native men (33.5/100,000) and women (18.4/100,000) than among Asian or Pacific Islander men (27.9/100,000) and women (11.4/100,000) and Hispanic or Latino men (23.1/100,000) and women (7.7/100,000), but lower than among Black or African American men (81.6/100,000) and women (27.2/100,000) and White men (54.9/100,000) and women (27.9/100,000).

Indiana is among the top five states in smoking prevalence. The 2001 Behavioral Risk Factor Surveillance System (BRFSS) found cigarette smoking prevalences of 40.0 percent among Indiana Black or African American residents age 18 years and older, 37.7 percent among Hispanic or Latino residents, 43.4 percent among White residents, and 42.6 percent among other multiracial group resident.

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – CANCER

Healthy People 2010 provides 15 objectives specific to cancer. Of those 15 objectives, the most relevant to the purpose and objectives of the Healthy Indiana Minority Health Plan are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***. Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

CANCER OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
CAN-1 **HP2010 Ref: 3-1**	**Reduce the overall cancer death rate among Indiana's Black or African American population from 274.9 cancer deaths per 100,000 Black or African American persons (2000) to 192.4 cancer deaths per 100,000 Black or African American persons (reduce to InMHAC target of 30% improvement).**	• **Total: 221.9 per 100,000** • **American Indian or Alaska Native: 48.0 per 100,000** • **Asian or Pacific Islander: 78.0 per 100,000** • **Black or African American: 274.9 per 100,000** • **Hispanic or Latino: 154.5 per 100,000** • **White: 221.5 per 100,000**
CAN-S1.1	*Increase opportunities for health professionals to counsel their Black or African American at-risk patients about tobacco use cessation, physical activity, and cancer screening.*	
CAN-S1.2	*Expand the statewide population-based cancer registry to capture case information on at least 95 percent of the expected number of reportable cancers among Indiana's*	

	Black or African American population.	
CAN-2 **HP2010 Ref: 3-2**	**Reduce the lung and bronchus cancer death rate for males among Indiana's Black or African American population from 110.7 lung and bronchus cancer deaths per 100,000 Black or African American males (2000) to 86.3 deaths per 100,000 Black or African American males (reduce to HP2010 target of 22% improvement).**	• **Total: 94.4 per 100,000 males** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available/significant** • **Black or African American: 110.7 per 100,000 males** • **Hispanic or Latino: Data are not available/significant** • **White: 94.8 per 100,000 males**
CAN-3 **HP2010 Ref: 3-2**	**Reduce the lung and bronchus cancer death rate for females among Indiana's Black or African American population from 53.7 lung and bronchus cancer deaths per 100,000 Black or African American females (2000) to 41.9 deaths per 100,000 Black or African American females (reduce to HP2010 target of 22% improvement).**	• **Total: 49.4 per 100,000 females** • **American Indian or Alaska Native: Data are not available/significant** • **Asian or Pacific Islander: Data are not available/significant** • **Black or African American: 53.7 per 100,000 females (Data not significant)** • **Hispanic or Latino: Data are not available** • **White: 49.7 per 100,000 females**
CAN-S2.1 – CAN-S3.1	*Increase opportunities for more Black or African American males and females to be screened for lung and bronchus cancer and educated on the impact of cancer risk factors.*	
CAN-S2.2 – CAN-S3.2	*Expand the statewide Behavioral Risk Factors Surveillance System to look at the factors within Black or African American male and female communities that lead to tobacco use and to identify points of intervention and prevention.*	
CAN-S2.3 – CAN-S3.3 Cross Ref: *AST-S1.6*	*Increase the number, specificity, and effectiveness of community-focused tobacco prevention and smoking cessation courses and the number of Black or African American male and females served by such courses within their community.*	
CAN-S2.4 – CAN-S3.4 Cross Ref: *AST-S1.7*	*Convince the government, industry, and health care providers on the importance of making smoking cessation products (e.g., patches) affordable and accessible within the Black or African American community.*	
CAN-S2.5 – CAN-S3.5 Cross Ref: *AST-S1.8*	*Promote among Indiana's health care professionals, community and political leaders, and general public the findings, recommendations, and proposed actions advanced by the Indiana Tobacco Disparity and Diversity (ITDD) Strategic Plan.*	
CAN-S2.6 – CAN-S3.6 Cross Ref:	*Continue to promote the Indiana Tobacco Prevention and Cessation Agency "smoke outside of the home" messages to parents of Black or African American children.*	

AST-S1.9		
CAN-4 **HP2010 Ref: 3-3**	**Reduce the breast cancer death rate for females among Indiana's Black or African American population from 39.9 breast cancer deaths per 100,000 Black or African American females (2000) to 31.9 deaths per 100,000 Black or African American females (reduce to HP2010 target of 20% improvement).**	• **Total: 28.8 per 100,000 females** • **American Indian or Alaska Native: Data are not available/significant** • **Asian or Pacific Islander: Data are not available/significant** • **Black or African American: 39.9 per 100,000 females** • **Hispanic or Latino: Data are not available/significant** • **White: 28.4 per 100,000 females**
CAN-5 **HP2010 Ref: 3-13**	**Increase the proportion of women aged 40 years and older among Indiana's Black or African American population who have received a mammogram within the preceding 2 years from 85.2% (2000) to 90.0% of Black or African American women aged 40 years and older (increase to InMHAC target).**	• **Total: 82.8%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 85.2%** • **Hispanic or Latino: Data are not available** • **White: 82.5%**
CAN-6 **HP2010 Ref: 3-4**	**Reduce the death rate from cancer of the uterine cervix among Indiana's Black or African American population from 4.9 cervical cancer deaths per 100,000 Black or African American females (2000) to 3.3 deaths per 100,000 Black or African American females (reduce to HP2010 target of 33% improvement).**	• **Total: 3.1 per 100,000 females** • **American Indian or Alaska Native: Data are not available/significant** • **Asian or Pacific Islander: Data are not available/significant** • **Black or African American: 4.9 per 100,000 females** • **Hispanic or Latino: Data are not available/significant** • **White: 3.1 per 100,000 females**
CAN-7 **HP2010 Ref: 3-11**	**Increase the proportion of women among Indiana's Black or African American population who receive a Pap test from 96.4% (2000) to 100% of Black or African American women aged 18 years and older who have ever received a Pap test and from 89.4% (2000) to 100% of Black or African American women aged 18 years and older who received a Pap test within the preceding 3 years (increase to InMHAC target).**	• **Total: 93.9% ever – 85.5% in past 3 years** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 96.4% ever – 89.4% in past 3 years** • **Hispanic or Latino: Data are not available** • **White: 94.0% ever – 84.7% in past 3 years**
CAN-S4.1 – CAN-S7.1	*Increase opportunities for Black or African American females to learn more about breast cancer and cancer of the uterine cervix, and the importance and methods of early detection through culturally appropriate promotional, educational, and community campaigns.*	
CAN-S4.2 –	*Increase the number, availability, and outreach of early detection programs (e.g.,*	

CAN-S7.2	*Indiana Breast and Cervical Cancer Early Detection Program), the number of females who are enrolled in and benefited by such programs, and opportunities for routine screening, appropriate follow-up, and treatment within the Black or African American community.*	
CAN-S4.3 – CAN-S7.3	*Increase opportunities for health care and social work professionals and other care givers to learn more about the availability and importance of the state's Breast and Cervical Cancer Early Detection Program.*	
CAN-S4.4 – CAN-S7.4	*Provide information and/or offer the services of the Indiana Breast and Cervical Cancer Early Detection Program at state and federally funded community health centers.*	
CAN-S4.5 – CAN-S7.5	*Increase opportunities for Black or African American females to learn more about the importance and methods of breast self-examinations.*	
CAN-S4.6 – CAN-S7.6	*Increase opportunities for Black or African American females to learn more about the importance of regularly scheduled mammograms.*	
CAN-S4.7 – CAN-S7.7	*Increase opportunities for Black or African American females to learn more about the importance of regularly scheduled Pap tests.*	
CAN-S4.8 – CAN-S7.8	*Promote among Indiana's health care professionals the use of the guidelines, recommendations, and protocols for breast and cervical cancer screening, diagnosis, and management advanced by the National Breast and Cervical Cancer Early Detection Program (NBCCEDP).*	
CAN-8 **HP2010 Ref: 3-5**	**Reduce the colorectal cancer death rate for males among Indiana's Black or African American population from 42.9 colorectal cancer deaths per 100,000 Black or African American males (2000) to 28.3 deaths per 100,000 Black or African American males (reduce to HP2010 target of 34% improvement).**	• **Total: 28.6 per 100,000 males** • **American Indian or Alaska Native: Data are not available/significant** • **Asian or Pacific Islander: Data are not available/significant** • **Black or African American: 42.9 per 100,000 males** • **Hispanic or Latino: Data are not available/significant** • **White: 28.1 per 100,000 males**
CAN-9 **HP2010 Ref: 3-5**	**Reduce the colorectal cancer death rate for females among Indiana's Black or African American population from 21.4 colorectal cancer deaths per 100,000 Black or African American females (2000) to 14.1 deaths per 100,000 Black or African American females (reduce to HP2010 target of 34% improvement).**	• **Total: 20.2 per 100,000 females** • **American Indian or Alaska Native: Data are not available/significant** • **Asian or Pacific Islander: Data are not available/significant** • **Black or African American: 21.4 per 100,000 females** • **Hispanic or Latino: Data are not available/significant** • **White: 18.6 per 100,000 females**
CAN-10 **HP2010 Ref: 3-12**	**Increase the proportion of adults among Indiana's Black or African American population who receive a colorectal cancer screening examination from 38.7% (2001) to**	• **Total: 44.7%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available**

	50.0% of Black or African American adults aged 50 years and older who have ever received sigmoidoscopy (increase to HP2010 target).	• **Black or African American: 38.7%** • **Hispanic or Latino: Data are not available** • **White: 45.1%**
CAN-S8.1 – CAN-S10.1	*Increase opportunities for Black or African American adults to learn more about colorectal cancer and the importance and methods of early detection through culturally appropriate promotional, educational, and community campaigns.*	
CAN-S8.2 – CAN-S10.2	*Increase funding and opportunities for colorectal cancer screenings among Black or African American adults who may be at-risk for colorectal cancer.*	
CAN-11 **HP2010 Ref: 3-7**	**Reduce the prostate cancer death rate among Indiana's Black or African American population from 73.9 prostate cancer deaths per 100,000 Black or African American males (2000) to 44.3 deaths per 100,000 Black or African American males (reduce to InMHAC target of 40% improvement).**	• **Total: 31.4 per 100,000 males** • **American Indian or Alaska Native: Data are not available/significant** • **Asian or Pacific Islander: Data are not available/significant** • **Black or African American: 73.9 per 100,000 males** • **Hispanic or Latino: Data are not available/significant** • **White: 29.3 per 100,000 males**
CAN-S11.1	*Increase opportunities for Black or African American males to learn more about prostate cancer and the importance and methods of early detection through culturally appropriate promotional, educational, and community campaigns.*	
CAN-S11.2	*Increase funding and opportunities for prostate cancer screenings among Black or African American males who may be at-risk for the disease.*	
CAN-12 **HP2010 Ref: 3-6**	**Reduce the oropharyngeal cancer death rate among Indiana's Black or African American population from 5.1 oropharyngeal cancer deaths per 100,000 Black or African American persons (2000) to 3.1 deaths per 100,000 Black or African American persons (reduce to InMHAC target of 40% improvement).**	• **Total: 2.6 per 100,000** • **American Indian or Alaska Native: Data are not available/significant** • **Asian or Pacific Islander: Data are not available/significant** • **Black or African American: 5.1 per 100,000** • **Hispanic or Latino: Data are not available/significant** • **White: 2.4 per 100,000**
CAN-S12.1	*Increase opportunities for the Black or African American population to learn more about oropharyngeal cancer and the importance and methods of early detection through culturally appropriate promotional, educational, and community campaigns.*	
CAN-S12.2	*Increase funding and opportunities for oropharyngeal cancer screenings among Black or African American persons who may be at-risk for the disease.*	

OBJECTIVES UNSUPPORTED BY INDIANA-SPECIFIC BASELINE DATA – CANCER

CANCER UNSUPPORTED OBJECTIVES AND *POTENTIAL STRATEGIC ACTIONS/INTERVENTIONS*		INDIANA BASELINE NOT AVAILABLE
CAN-U1 HP2010 Ref: 3-12	Increase the proportion of adults among Indiana's racial and ethnic populations who receive a colorectal cancer screening examination from X% (2001) to 50% of racial and ethnic minority adults aged 50 years and older who have received a fecal occult blood test (FOBT) within the preceding 2 years (increase to HP2010 target).	• Total: 67.1% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: 67.2%
	Potential Strategies: CAN-S10.1 – CAN-S10.2	
CAN-U2 HP2010 Ref: 3-15	Increase the proportion of cancer survivors among Indiana's racial and ethnic populations who are living 5 years or longer after diagnosis from X% (2000) to X% (increase to HP20120 target of 19% improvement).	• Total: X% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: X%
CAN-SU2.1	*Increase opportunities for Black or African American persons to learn more about cancer, its risk factors, and the importance and methods of early detection through culturally appropriate promotional, educational, and community campaigns.*	
CAN-SU2.2	*Increase funding and opportunities for cancer screenings among Black or African American persons who may be at-risk for cancer.*	
CAN-SU2.3	*Increase the number and availability of early cancer detection programs within the Black or African American community and the number of persons who are enrolled in and benefited by such programs.*	

STROKE

RATIONALE

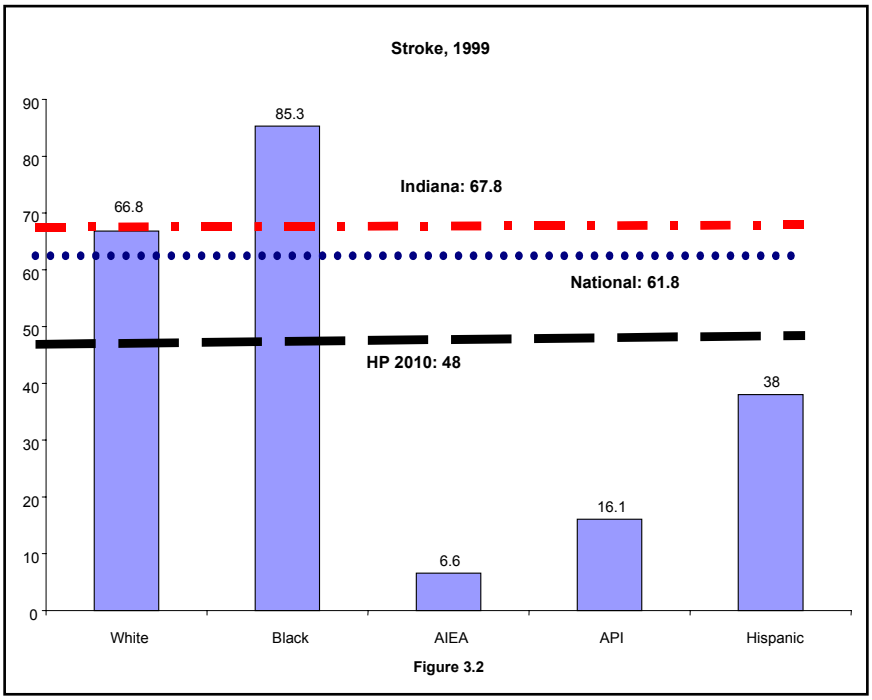
The CDC reports that 167,000 people die of stroke in the U.S. (121/100,000), making it the ***third leading cause of death***. The chance of having a stroke increases with age. Although only 25% of stroke deaths among Whites occur before age 75, the percentage increases to 49% for Blacks or African Americans.

Stroke Mortality Risk Relative to Total Indiana Population
Indiana, 2000

American Indian or Alaska Native:	**0.3**
Asian or Pacific Islander:	**0.6**
Black or African American:	**1.3**
Hispanic or Latino:	**0.8**
White:	**1.0**

Blacks or African Americans have a higher stroke risk and are more likely to die of stroke than other racial and ethnic groups, with age-adjusted death rates in the 35 years and older population (166/100,000) that are 2.1 times higher than the rates of Hispanics or Latinos (79/100,000) and American Indians or Alaska Natives (79/100,000), 1.6 times higher than the rates for Asians or Pacific Islanders (105/100,000), and 1.4 times higher than the rates for Whites (117/100,000).

In Indiana, the age-adjusted stroke death rate for residents age 35 years and older in1991-98 was 162/1000 for Blacks or African Americans, 136/100,000 for Whites, 60/100,000 for Hispanics or Latinos, and 57/100,000 for Asians and Pacific Islanders. Data were not reported for American Indians or Alaska Natives. The rate for Indiana was 138/100,000.



Rates per 100,000 population (columns reflect Indiana data)

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – STROKE

Healthy People 2010 provides 2 objectives specific to stroke and another 8 specific to blood pressure and cholesterol. Of those 10 objectives, the most relevant to the purpose and objectives of the Healthy Indiana Minority Health Plan are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***. Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

STROKE OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
STR-1 **HP2010 Ref: 12-7**	**Reduce stroke deaths among Indiana's Black or African American population from 92.3 deaths from stroke per 100,000 Black or African American persons (2000) to 55.4 deaths per 100,000 Black or African American persons (reduce to InMHAC target of 40% improvement).**	• **Total: 74.0 per 100,000** • **American Indian or Alaska Native: 20.8 per 100,000** • **Asian or Pacific Islander: 43.9 per 100,000** • **Black or African American: 92.3 per 100,000** • **Hispanic or Latino: 62.5 per 100,000** • **White: 73.3 per 100,000**
STR-2 **HP2010 Ref: 12-7**	**Reduce stroke deaths among Indiana's Hispanic or Latino population from 62.5 deaths from stroke per 100,000 Hispanic or Latino persons (2000) to 53.1 deaths per 100,000 Hispanic or Latino persons (reduce to InMHAC target of 15% improvement).**	• **Total: 74.0 per 100,000** • **American Indian or Alaska Native: 20.8 per 100,000** • **Asian or Pacific Islander: 43.9 per 100,000** • **Black or African American: 92.3 per 100,000** • **Hispanic or Latino: 62.5 per 100,000** • **White: 73.3 per 100,000**
STR-S1.1 – STR-S2.1	*Work closely with the American Heart Association Operation Stroke and the American Red Cross to increase opportunities to educate Black or African American and Hispanic or Latino adolescents and adults about the risk factors and the early warning symptoms and signs of stroke.*	
STR-S1.2 – STR-S2.2	*Work closely with the American Heart Association Operation Stroke and the American Red Cross to increase opportunities to educate Black or African American and Hispanic or Latino adolescents and adults on the awareness of early interventions for stroke.*	
STR-S1.3 – STR-S2.3	*Work closely with the American Heart Association Operation Stroke and the American Red Cross to increase Black or African American and Hispanic or Latino compliance with the Indiana Consensus Guidelines for Cardiovascular Care.*	

STR-3 **HP2010 Ref: 12-9** **Cross Ref: CVD-3**	**Reduce the proportion of adults among Indiana's Black or African American population with high blood pressure from 35.6% of Black or African American adults aged 20 years and older (2001) to 16.0% (reduce to HP2010 target).**	• **Total: 25.7%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 35.6%** • **Hispanic or Latino: 15.8%** • **White: 25.2%**
STR-S3.1 Cross Ref: *CVD-S3.1*	*Work with the Office of Medicaid/Medicare Planning to do population sampling and use Geographic Information Systems (GIS) to locate, identify, and target Black or African American communities with high incidence and prevalence of high blood pressure.*	
STR-S3.2 Cross Ref: *CVD-S3.2*	*Increase opportunities to educate Black or African American adults about the dangers of high blood pressure and its complications (e.g., damage to the heart, blood vessels, brain, kidneys, and eyes), and the behaviors that the increase risk for high blood pressure (e.g., cigarette smoking, obesity, physical inactivity, high dietary fat and sodium, excessive alcohol consumption, etc.).*	
STR-S3.3 Cross Ref: *CVD-S3.3*	*Develop educational campaigns and clinical interventions that promote and support therapeutic lifestyle changes and heart healthy behavior (e.g., smoking cessation; high and low intensity exercise such as walking, jogging, basketball, house/yard work.; weight reduction; reduced intake of saturated fats and cholesterol as in the DASH [Dietary Approaches to Stop Hypertension] eating plan; etc.) among people with high blood pressure.*	
STR-S3.4 Cross Ref: *CVD-S3.4*	*Promote among Black or African American populations, as an adjunct to the need for regular follow-up visits and therapy, the methods of monitoring blood pressure at home (e.g., self-measurement) with the rationale that home monitoring improves therapeutic compliance and response.*	
STR-S3.5 Cross Ref: *STR-S4.1 – STR-S7.1 CVD-S3.5 CVD-S4.1 – CVD-S7.1*	*Promote among Indiana's health care professionals the use of the Indiana Consensus Guidelines for cardiovascular disease.*	
STR-S3.6 Cross Ref: *CVD-S3.6*	*Promote among Indiana's health care professionals the use of the guidelines, recommendations, and protocols for high blood pressure measurement and management advanced by the National High Blood Pressure Education Program and the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (e.g., JNC VI).*	
STR-S3.7 Cross Ref: *CVD-S3.7*	*Promote among Indiana's health care professionals the use of the consensus recommendations of the Hypertension in African Americans Working Group of the International Society on Hypertension in Blacks.*	
STR-S3.8 Cross Ref:	*Promote among Indiana's health care professionals the recommendations and protocols for assessing and managing overweight and obesity advanced by the Obesity Education Initiative of the National Heart, Lung, and Blood Institute, the Clinical*	

CVD-S3.8 *DIA-S1.6 – DIA-S3.6*	*Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, and the Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults.*	
STR-S3.9 Cross Ref: *CVD-S3.9* *DIA-S1.8 – DIA-S3.8*	*Promote among Indiana's health care professionals the recommendations on intensive behavioral dietary counseling for adult patients with high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease, such as high blood pressure and obesity, as provided in the Guide to Clinical Preventive Services (Counseling to Promote a Healthy Diet) advanced by the U.S. Preventive Services Task Force.*	
STR-S3.10 Cross Ref: *CVD-S3.10* *DIA-S1.12 – DIA-S3.12*	*Promote among racial and ethnic minority communities the availability and importance of enrolling in Chronic Disease Self-Management courses offered through the Indiana Minority Health Coalition.*	
STR-4 **HP2010 Ref: 12-14** **Cross Ref: CVD-4**	**Reduce the proportion of adults among Indiana's Black or African American population with high total blood cholesterol levels from 20.5% of Black or African adults aged 20 years and older (2001) to 17.0% (reduce to HP2010 target).**	• **Total: 29.9%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 20.5%** • **Hispanic or Latino: 28.4%** • **White: 30.8%**
STR-5 **HP2010 Ref: 12-14** **Cross Ref: CVD-5**	**Reduce the proportion of adults among Indiana's Hispanic or Latino population with high total blood cholesterol levels from 28.4% of Hispanic or Latino adults aged 20 years and older (2001) to 17.0% (reduce to HP2010 target).**	• **Total: 29.9%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 20.5%** • **Hispanic or Latino: 28.4%** • **White: 30.8%**
STR-6 **HP2010 Ref: 12-15** **Cross Ref: CVD-6**	**Increase the proportion of adults among Indiana's Black or African American population who have had their blood cholesterol checked within the preceding 5 years from 74.8% of Black or African American adults aged 18 years and older (2001) to 85.0% (increase to InMHAC target).**	• **Total: 69.9%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 74.8%** • **Hispanic or Latino: 53.1%** • **White: 70.2%**
STR-7 **HP2010 Ref: 12-15** **Cross Ref: CVD-7**	**Increase the proportion of adults among Indiana's Hispanic or Latino population who have had their blood cholesterol checked within the preceding 5 years from 53.1% of Hispanic or Latino adults aged 18 years and older (2001) to 85.0% (increase to InMHAC target).**	• **Total: 69.9%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 74.8%** • **Hispanic or Latino: 53.1%** • **White: 70.2%**

STR-S4.1 – STR-S7.1 Cross Ref: *STR-S3.5 CVD-S3.5 CVD-S4.1 – CVD-S7.1*	*Promote among Indiana's health care professionals the use of the Indiana Consensus Guidelines for cardiovascular disease.*
STR-S4.2 – STR-S7.2 Cross Ref: *CVD-S4.2 – CVD-S7.2*	*Promote among Indiana's health care professionals the use of the guidelines, recommendations, and protocols for cholesterol testing and management advanced by the National Cholesterol Education Program and the Expert Panel on Detection, Evaluation, and Treatment of High Blood Cholesterol in Adults (Adult Treatment Panel [ATP] III).*

OBJECTIVES UNSUPPORTED BY INDIANA-SPECIFIC BASELINE DATA – STROKE

STROKE UNSUPPORTED OBJECTIVES AND *POTENTIAL STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE NOT AVAILABLE**
STR-U1 HP2010 Ref: 12-10 Cross Ref: CVD-U1	Increase the proportion of adults among Indiana's Black or African American population with high blood pressure whose blood pressure is under control from X% of Black or African American adults aged 18 years and older with high blood pressure (2000) to 50% (increase to HP2010 target).	• Total: X% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: X%
STR-U2 HP2010 Ref: 12-11 Cross Ref: CVD-U2	Increase the proportion of adults among Indiana's Black or African American population with high blood pressure who are taking action (for example, smoking cessation, losing weight, increasing physical activity, reducing sodium intake, and compliance with therapeutic regimens) to help control their blood pressure from X% of Black or African American adults aged 18 years and older with high blood pressure (2000) to 95% (increase to HP2010 target).	• Total: X% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: X%
STR-U3 HP2010 Ref: 12-12 Cross Ref: CVD-U3	Increase the proportion of adults among Indiana's Black or African American population who have had their blood pressure measured within the preceding year and can state whether their blood pressure was normal or high from X% of Black or African American adults aged 18 years and older (2000) to 95 %	• Total: X% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: X%

	(increase to HP2010 target).	
	Potential Strategies: *STR-S3.1 – STR-S3.10*	
STR-U4 HP2010 Ref: 12-13 Cross Ref: CVD-U4	Reduce the mean total blood cholesterol levels of adults among Indiana's racial and ethnic populations from X mg/dL for racial and ethnic minority adults aged 20 years and older (2000) to 199 mg/dL (reduce to HP2010 target).	• Total: X mg/dL • American Indian or Alaska Native: X mg/dL • Asian or Pacific Islander: X mg/dL • Black or African American: X mg/dL • Hispanic or Latino: X mg/dL • White: X mg/dL
	Potential Strategies: *STR-S4.1 – STR-S7.1* *STR-S4.2 – STR-S7.2*	

ASTHMA

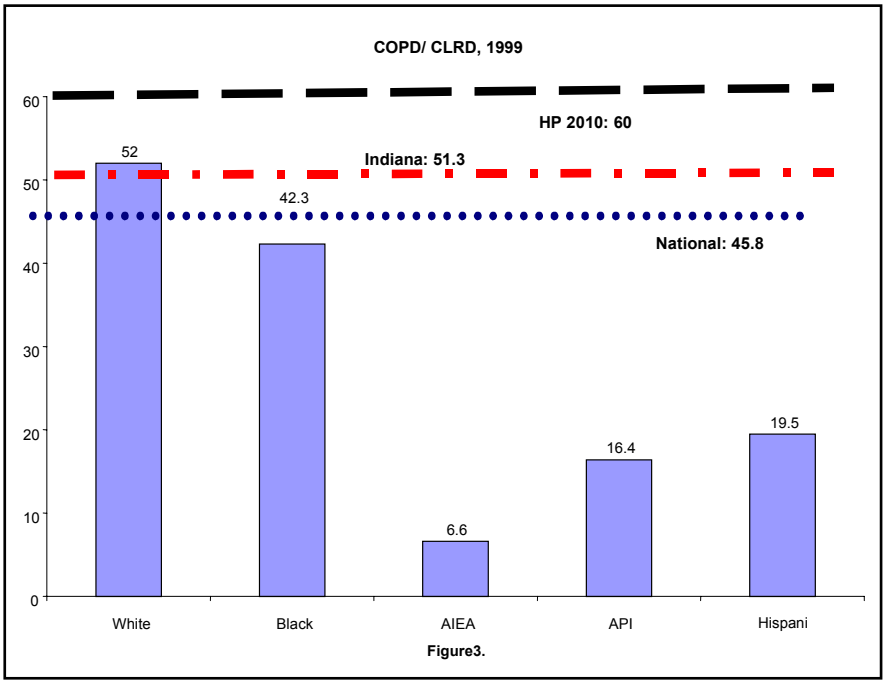
RATIONALE

Percent of Population Told by Health Professional They Have Asthma Indiana, 2001	
Black or African American:	12.6
Hispanic or Latino:	11.0
White:	11.3

The ICD 10 classification of COPD adds asthma to emphysema and bronchitis and renames the condition to Chronic Lower Respiratory Disease (CLRD). In 1999, 124,181 people in the U.S. died of COPD, making COPD the 4th leading cause of death in the nation with a death rate of 45.8 per 100,000 people. Males generally have a higher rate of COPD/CLRD, but in 1999 females had a higher rate of asthma.

Smoking is one of the highest risk factors for COPD/CLRD. The American Lung Association reported that the prevalence of smoking nationally is highest among American Indians or Alaska Natives (34.1 percent), followed by Blacks or African Americans (26.7 percent), Whites (25.3 percent), Hispanics or Latinos (20.4 percent), and Asians or Pacific Islanders (16.9 percent).

The COPD/CLRD death rate per 100,000 population in the U.S. is highest among Whites at 51.1/100,000. The COPD/CLRD death rate is 22.7 for Blacks or African Americans, 21.4 for American Indians or Alaska Natives, 10.4 for Asians or Pacific Islanders, and 9.1 for Hispanics or Latinos. According to the American Lung Association, COPD/CLRD is the only lung disease in which Whites are profusely affected, and the only lung disease type in which the age-adjusted death rate for Whites exceeds that for Blacks nationally.



Rates per 100,000 population (columns reflect Indiana data)

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – ASTHMA

Healthy People 2010 provides 12 objectives specific to asthma, chronic obstructive pulmonary disease/chronic lower respiratory disease, and obstructive sleep apnea. Of those 14 objectives, the most relevant to the purpose and objectives of the Healthy Indiana Minority Health Plan are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***. Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

ASTHMA OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
AST-1 **HP2010 Ref: 24-1**	**Reduce asthma deaths among Indiana's Black or African American population from 6.3 asthma deaths per 100,000 Black or African American persons (2000) to 3.8 deaths per 100,000 Black or African American persons (reduce to InMHAC target of 40% improvement).**	• **Total: 1.4 per 100,000** • **American Indian or Alaska Native: Data are not available/significant** • **Asian or Pacific Islander: 1.0 per 100,000** • **Black or African American: 6.3 per 100,000** • **Hispanic or Latino: Data are not available/significant** • **White: 1.0 per 100,000**
AST-S1.1	*Increase opportunities for Black or African American persons with asthma to receive appropriate asthma care according to the National Asthma Education and Prevention Program (NAEPP) Guidelines.*	
AST-S1.2	*Increase opportunities to improve financial and geographic access to appropriate and timely primary care for Black or African American persons with asthma.*	
AST-S1.3	*Establish a statewide surveillance system for tracking Black or African American asthma death, illness, disability, and impact of occupational and environmental factors on asthma, access to medical care, and asthma management.*	
AST-S1.4	*Use effective case management as a Medicaid benefit to monitor asthma among Black or African American persons with moderate to severe asthma.*	
AST-S1.5	*Promote among Indiana's health care professionals the use of the guidelines, recommendations, and protocols for the diagnosis and management of asthma advanced by the National Asthma Education and Prevention Program Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma (EPR-2).*	
AST-S1.6 Cross Ref: *CAN-S2.3 – CAN-S3.3*	*Increase the number, specificity, and effectiveness of community-focused tobacco prevention and smoking cessation courses and the number of Black or African American male and females served by such courses within their community.*	

AST-S1.7 Cross Ref: *CAN-S2.4 – CAN-S3.4*	*Convince the government, industry, and health care providers on the importance of making smoking cessation products (e.g., patches) affordable and accessible within the Black or African American community.*	
AST-S1.8 Cross Ref: *CAN-S2.5 – CAN-S3.5*	*Promote among Indiana's health care professionals, community and political leaders, and general public the findings, recommendations, and proposed actions advanced by the Indiana Tobacco Disparity and Diversity (ITDD) Strategic Plan.*	
AST-S1.9 Cross Ref: *CAN-S2.6 – CAN-S3.6*	*Continue to promote the Indiana Tobacco Prevention and Cessation Agency "smoke outside of the home" messages to parents of Black or African American children.*	
AST-2 **HP2010 Ref: 24-5**	**Reduce the number of school or work days missed among Indiana's racial and ethnic populations by persons with asthma due to asthma.**	**Developmental HP2010 Objective (data not available nationally)**
AST-S2.1	*Increase awareness and compliance of health care providers in providing written asthma management plans to racial and ethnic minorities with asthma.*	
AST-S2.2	*Increase opportunities to provide racial and ethnic minorities with asthma increased access to formal asthma education programs that include information about community and self-help resources as an essential part of the management of their condition.*	
AST-S2.3	*Increase opportunities to provide racial and ethnic minorities with asthma who use prescribed inhalers instructions on the proper use of their inhalers.*	
AST-S2.4	*Increase opportunities to provide racial and ethnic minorities with asthma follow-up medical care for long-term management of asthma after any asthma related hospitalization.*	
AST-S2.5	*Increase opportunities to provide racial and ethnic minorities with asthma assistance in assessing and reducing exposure to environmental risk factors (e.g., second hand smoke, pollution, emotional stress) in their home, school, and work environments.*	
AST-S2.6	*Partner with local housing authorities to advocate for the elimination or control of respiratory irritants, trigger factors, and other potential sources of increased environmental risk for racial and ethnic minority patients with asthma.*	
AST-S2.7	*Provide Chronic Disease Self-Management training as part of effective case management to racial and ethnic minority adolescents and adults with asthma.*	

OBJECTIVES UNSUPPORTED BY INDIANA-SPECIFIC BASELINE DATA – ASTHMA

ASTHMA UNSUPPORTED OBJECTIVES AND *POTENTIAL STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE NOT AVAILABLE**
AST-U1 HP2010 Ref: 24-1a 24-1b	Reduce asthma deaths among Indiana's racial and ethnic populations for children aged 14 years and younger from X per 100,000 (2000) to 1.0 per 100,000 (reduce to HP2010 target).	• Total: X per 100,000 • American Indian or Alaska Native: X per 100,000 • Asian or Pacific Islander: X per 100,000 • Black or African American: X per 100,000 • Hispanic or Latino: X per 100,000 • White: X per 100,000
AST-U2 HP2010 Ref: 24-1c	Reduce asthma deaths among Indiana's racial and ethnic populations for adolescents and adults aged 15 to 34 years from X per 100,000 (2000) to 3.0 100,000 (reduce to HP2010 target).	• Total: X per 100,000 • American Indian or Alaska Native: X per 100,000 • Asian or Pacific Islander: X per 100,000 • Black or African American: X per 100,000 • Hispanic or Latino: X per 100,000 • White: X per 100,000
AST-U3 HP2010 Ref: 24-1d	Reduce asthma deaths among Indiana's racial and ethnic populations for adults aged 35 to 64 years from X per 100,000 (2000) to 9.0 per 100,000 (reduce to HP2010 target).	• Total: X per 100,000 • American Indian or Alaska Native: X per 100,000 • Asian or Pacific Islander: X per 100,000 • Black or African American: X per 100,000 • Hispanic or Latino: X per 100,000 • White: X per 100,000
AST-U4 HP2010 Ref: 24-1e	Reduce asthma deaths among Indiana's racial and ethnic populations for adults aged 65 years and older from X per 100,000 (2000) to 60.0 per 100,000 (reduce to HP2010 target).	• Total: X per 100,000 • American Indian or Alaska Native: X per 100,000 • Asian or Pacific Islander: X per 100,000 • Black or African American: X per 100,000 • Hispanic or Latino: X per 100,000 • White: X per 100,000
AST-SU1.1 – AST-SU4.1	*Increase opportunities for racial and ethnic minorities with asthma to receive appropriate asthma care according to the National Asthma Education and Prevention Program (NAEPP) Guidelines.*	
AST-SU1.2 – AST-SU4.2	*Increase opportunities to improve financial and geographic access to appropriate and*	

	timely primary care for racial and ethnic minorities with asthma.	
AST-SU1.3 – AST-SU4.3	*Establish a statewide surveillance system within racial and ethnic minority populations for tracking asthma death, illness, disability, and impact of occupational and environmental factors on asthma, access to medical care, and asthma management.*	
AST-SU1.4 – AST-SU4.4	*Use effective case management as a Medicaid benefit to monitor asthma among Black or African American persons with moderate to severe asthma.*	
AST-SU1.5 – AST-SU4.5	*Promote among Indiana's health care professionals the use of the guidelines, recommendations, and protocols for the diagnosis and management of asthma advanced by the National Asthma Education and Prevention Program Expert Panel Report 2: Guidelines for the Diagnosis and Management of Asthma (EPR-2).*	
AST-SU1.6 – AST-SU4.6	*Continue to promote the Indiana Tobacco Prevention and Cessation Agency "smoke outside of the home" messages to parents of racial and ethnic minority children.*	
	Other Potential Strategies: *AST-S2.7*	
AST-U5 HP2010 Ref: 24-2a	Reduce hospitalizations for asthma among Indiana's racial and ethnic populations for children under 5 years from X per 10,000 (2000) to 25.0 per 10,000 (reduce to HP2010 target).	• Total: X per 10,000 • American Indian or Alaska Native: X per 10,000 • Asian or Pacific Islander: X per 10,000 • Black or African American: X per 10,000 • Hispanic or Latino: X per 10,000 • White: X per 10,000
AST-U6 HP2010 Ref: 24-2b	Reduce hospitalizations for asthma among Indiana's racial and ethnic populations for children and adults aged 5 to 64 years from X per 10,000 (2000) to 8.0 per 10,000 (reduce to HP2010 target).	• Total: X per 10,000 • American Indian or Alaska Native: X per 10,000 • Asian or Pacific Islander: X per 10,000 • Black or African American: X per 10,000 • Hispanic or Latino: X per 10,000 • White: X per 10,000
AST-U7 HP2010 Ref: 24-2c	Reduce hospitalizations for asthma among Indiana's racial and ethnic populations for adults aged 65 years and older from X per 10,000 (2000) to 10.0 per 10,000 (reduce to HP2010 target).	• Total: X per 10,000 • American Indian or Alaska Native: X per 10,000 • Asian or Pacific Islander: X per 10,000 • Black or African American: X per 10,000 • Hispanic or Latino: X per 10,000 • White: X per 10,000
	Potential Strategies: *AST-S2.6* *AST-SU1.1 – AST-SU4.1* *AST-SU1.2 – AST-SU4.2*	

AST-U8 HP2010 Ref: 24-3a	Reduce hospital emergency department visits for asthma among Indiana's racial and ethnic populations for children under 5 years from X per 10,000 (2000) to 80.0 per 10,000 (reduce to HP2010 target).	• Total: X per 10,000 • American Indian or Alaska Native: X per 10,000 • Asian or Pacific Islander: X per 10,000 • Black or African American: X per 10,000 • Hispanic or Latino: X per 10,000 • White: X per 10,000
AST-U9 HP2010 Ref: 24-3b	Reduce hospital emergency department visits for asthma among Indiana's racial and ethnic populations for children and adults aged 5 to 64 years from X per 10,000 (2000) to 50.0 per 10,000 (reduce to HP2010 target).	• Total: X per 10,000 • American Indian or Alaska Native: X per 10,000 • Asian or Pacific Islander: X per 10,000 • Black or African American: X per 10,000 • Hispanic or Latino: X per 10,000 • White: X per 10,000
AST-U10 HP2010 Ref: 24-3c	Reduce hospital emergency department visits for asthma among Indiana's racial and ethnic populations for adults aged 65 years and older from X per 10,000 (2000) to 15.0 per 10,000 (reduce to HP2010 target).	• Total: X per 10,000 • American Indian or Alaska Native: X per 10,000 • Asian or Pacific Islander: X per 10,000 • Black or African American: X per 10,000 • Hispanic or Latino: X per 10,000 • White: X per 10,000
AST-U11 HP2010 Ref: 24-4	Reduce activity limitations of persons with asthma among Indiana's racial and ethnic populations from X% of persons with asthma (2000) to 10.0% (reduce to HP2010 target).	• Total: X% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: X%
AST-SU8.1 – AST-SU11.1	*Increase opportunities to educate racial and ethnic minorities with asthma and their caregivers about recognizing early signs and symptoms of asthma episodes and how to respond appropriately, including instruction on peak flow monitoring for those who use daily therapy.*	
	Other Potential Strategies:	*AST-S2.1 – AST-S2.7* *AST-SU1.1 – AST-SU4.1* *AST-SU1.2 – AST-SU4.2* *AST-SU1.5 – AST-SU4.5* *AST-SU1.6 – AST-SU4.6*

DIABETES

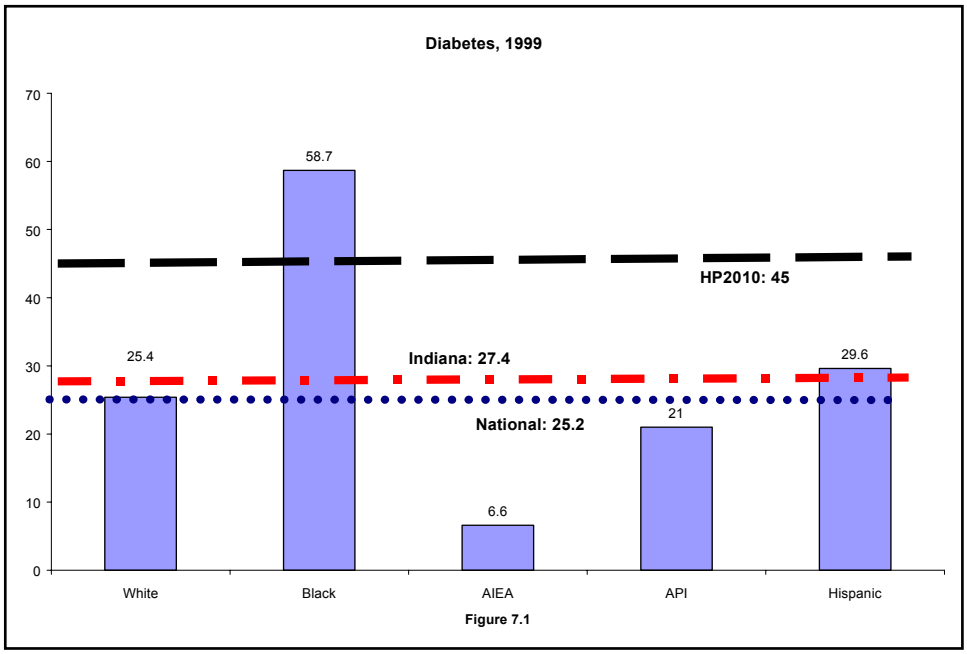
RATIONALE

Diagnosed Diabetes in Adults Aged 18 Years or Older Indiana, 2000	
Number:	279
Percent of Population:	6.9
Rate of Increase in Percent of Population (1990-2000):	21.0

Diabetes was the sixth leading cause of death in the U.S. in 1999, and approximately 6 million of the 17 million people with diabetes (6.2% of the population) are undiagnosed. High blood pressure, heart disease, and stroke are co-morbid complications of diabetes, such that people with diabetes are at greater risk than people without diabetes for other diseases targeted in this Plan.

According to the National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK), Blacks or African Americans, Hispanics or Latinos, American Indians or Alaska Natives, and some Asians or Pacific Islanders are at high risk for type 2 diabetes.

The U.S. prevalence of diabetes is 2.6 times higher in American Indians or Alaska Natives, 2.0 times higher in Blacks or African Americans, and 1.9 times higher in Hispanics or Latinos than in Whites; 105,000 American Indians or Alaska Natives (15.1% of those receiving care from the Indian Health Service), 2.8 million Blacks or African Americans (13%), and 2 million Hispanics or Latinos (10.2%) have diabetes. Diabetes prevalence data are limited for Asians or Pacific Islanders.



Rates per 100,000 population (columns reflect Indiana data)

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – DIABETES

Healthy People 2010 provides 17 objectives specific to diabetes. Of those 17 objectives, the most relevant to the purpose and objectives of the Healthy Indiana Minority Health Plan are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***. Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

DIABETES OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
DIA-1 **HP2010 Ref: 5-3**	**Reduce the prevalence of diabetes among Indiana's Black or African American population from 53.0 cases of diabetes per 1,000 Black or African American persons (1999) to 26.5 cases per 1,000 Black or African American persons (reduce to InMHAC target of 50% improvement).**	• **Total: 45.0 per 1,000** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 53.0 per 1,000** • **Hispanic or Latino: Data are not available** • **White: 45.3 per 1,000**
DIA-2 **HP2010 Ref: 5-5**	**Reduce the diabetes death rate among Indiana's Black or African American population from 57.4 deaths per 100,000 Black or African American persons (2000) to 28.7 deaths per 100,000 Black or African American persons (reduce to InMHAC target of 50% improvement).**	• **Total: 29.0 per 100,000** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: 3.7 per 100,000** • **Black or African American: 57.4 per 100,000** • **Hispanic or Latino: 51.7 per 100,000** • **White: 27.5 per 100,000**
DIA-3 **HP2010 Ref: 5-5**	**Reduce the diabetes death rate among Indiana's Hispanic or Latino population from 51.7 deaths per 100,000 Hispanic or Latino persons (2000) to 25.9 deaths per 100,000 Hispanic or Latino persons (reduce to InMHAC target of 50% improvement).**	• **Total: 29.0 per 100,000** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: 3.7 per 100,000** • **Black or African American: 57.4 per 100,000** • **Hispanic or Latino: 51.7 per 100,000** • **White: 27.5 per 100,000**
DIA-S1.1 – DIA-S3.1	*Develop a partnership with the Indiana Diabetes Prevention and Control Program to help implement within Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority communities the Diabetes Control Plan for the state of*	

	Indiana.
DIA-S1.2 – DIA-S3.2	*Develop and maintain a state-based, population, relational data surveillance system that collects diabetes related data (e.g. diabetes status, service components, etc.) to measure and assess the health status of Indiana's Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority populations as outlined by the Indiana Diabetes Prevention and Control Program, and to more accurately target program efforts to identify and track diabetes among Indiana's racial and ethnic minority populations.*
DIA-S1.3 – DIA-S3.3	*Increase funding for the Behavioral Risk Factor Surveillance System (BRFSS) to increase the number of completed informational and data surveys obtained from Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority communities.*
DIA-S1.4 – DIA-S3.4	*Develop a Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority health profile that reports trends in health status, risk factors, and resource consumption.*
DIA-S1.5 – DIA-S3.5	*Increase funding to implement prevention programs targeted to Black or African American, Hispanic or Latino, and other high-risk racial and ethnic minority populations and communities.*
DIA-S1.6 – DIA-S3.6 Cross Ref: *CVD-S3.8 STR-S3.8*	*Promote among Indiana's health care professionals the recommendations and protocols for assessing and managing overweight and obesity advanced by the Obesity Education Initiative of the National Heart, Lung, and Blood Institute, the Clinical Guidelines on the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, and the Practical Guide to the Identification, Evaluation, and Treatment of Overweight and Obesity in Adults.*
DIA-S1.7 – DIA-S3.7	*Promote among Indiana's health care professionals the use of the Indiana Consensus Guidelines for Diabetes Care advanced by the Indiana Diabetes Prevention and Control Program of the Indiana State Department of Health.*
DIA-S1.8 – DIA-S3.8 Cross Ref: *CVD-S3.9 STR-S3.9*	*Promote among Indiana's health care professionals the recommendations on intensive behavioral dietary counseling for adult patients with high cholesterol and other known risk factors for cardiovascular and diet-related chronic disease, such as high blood pressure and obesity, as provided in the Guide to Clinical Preventive Services (Counseling to Promote a Healthy Diet) advanced by the U.S. Preventive Services Task Force.*
DIA-S1.9 – DIA-S3.9	*Increase access to routine diabetes screening and care for Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority populations in Indiana at risk for diabetes, particularly those with high blood pressure and/or high cholesterol as recommended by the U.S. Preventive Services Task Force.*
DIA-S1.10 – DIA-S3.10	*Expand opportunities and venues (schools, work sites, communities) for Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority populations in Indiana at risk for diabetes to receive formal education about risk factors, behavior modification, and effective self-management as a component of prevention and treatment.*
DIA-S1.11 – DIA-S3.11	*Develop and implement community-based and culturally sensitive outreach and education programs within Black or African American, Hispanic or Latino, and other*

	high risk racial and ethnic minority communities in Indiana.
DIA-S1.12 – DIA-S3.12 Cross Ref: *CVD-S3.10* *STR-S3.10*	*Promote through the Indiana Minority Health Coalition within Black or African American, Hispanic or Latino, and other high risk racial and ethnic minority communities in Indiana the availability and importance of enrolling in the Chronic Disease Self-Management courses sponsored by the Indiana Diabetes Prevention and Control Program.*
DIA-S1.13 – DIA-S3.13	*Control the complications of diabetes through the integrated and coordinated management and care of Black or African American and Hispanic or Latino patients with diabetes.*

OBJECTIVES UNSUPPORTED BY INDIANA-SPECIFIC BASELINE DATA – DIABETES

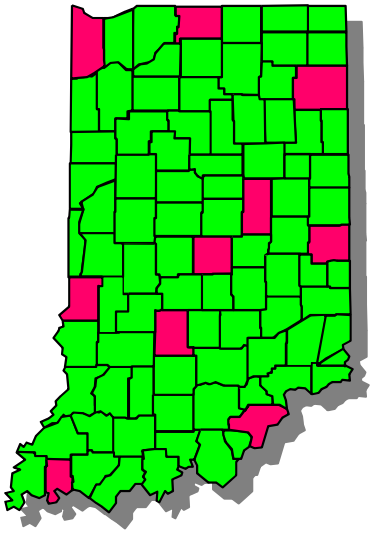
DIABETES UNSUPPORTED OBJECTIVES AND *POTENTIAL STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE NOT AVAILABLE**
DIA-U1 HP2010 Ref: 5-1	Increase the proportion of Indiana's racial and ethnic populations with diabetes who receive formal diabetes education from X% (2000) to 60% (increase to HP2010 target).	• Total: 56.8% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: 58.0%
DIA-SU1.1	*Develop a partnership with the Indiana Chronic Disease Advisory Council, the Indiana Diabetes Collaborative, the Indiana Diabetes Prevention and Control Program, and the Indiana Minority Health Coalition to expand the number, distribution, and type of formal and informal diabetes education programs for and within Indiana's racial and ethnic communities.*	
DIA-SU1.2	*Partner with the State Nutritionist and the Indiana Department of Education to develop, implement, and evaluate health education programs that focus the attention of administrators and cafeteria dieticians of public schools with high enrollment of students from racial and ethnic minority populations on the importance of culturally sensitive dietary patterns and appropriate, early nutrition intervention in establishing lifetime patterns for preventing obesity and diabetes.*	
DIA-SU1.3	*Partner with the Indiana Department of Education to develop, implement, and evaluate health education programs that focus the attention of administrators of public schools with high enrollment of students from racial and ethnic minority populations on the importance of proper, early exercise intervention and school-based physical activity programs in establishing lifetime patterns for preventing obesity and diabetes.*	
DIA-U2 HP2010 Ref: 5-2	Reduce the incidence of diabetes in Indiana's racial and ethnic populations from X new cases of diabetes per 1,000 persons per year (2000) to X new cases per 1,000 persons per year.	• Total: X per 1,000 • American Indian or Alaska Native: X per 1,000 • Asian or Pacific Islander: X per 1,000 • Black or African American: X per 1,000

		• Hispanic or Latino: X per 1,000 • White: X per 1,000
	Potential Strategies: *DIA-S1.1 – DIA-S1.13* *DIA-S2.1 – DIA-S2.13* *DIA-S3.1 – DIA-S3.13*	
DIA-U3 HP2010 Ref: 5-12	Increase the proportion of adults with diabetes in Indiana's racial and ethnic populations who have a glycosylated hemoglobin measurement at least once a year from X% of adults aged 18 years and older with diabetes (2000) to 50% (increase to HP2010 target).	• Total: 74.0% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: 76.2%
DIA-SU3.1	*Encourage diabetes continuing education for health professionals involved with diabetes management for racial and ethnic minorities.*	
DIA-U4 HP2010 Ref: 5-13	Increase the proportion of adults with diabetes in Indiana's racial and ethnic populations who have an annual dilated eye examination from X% of adults aged 18 years and older with diabetes (2000) to 75% (increase to HP2010 target).	• Total: 66.2% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: 67.6%
DIA-SU4.1	*Control the complications of diabetes through the integrated and coordinated management and care of racial and ethnic minority patients with diabetes.*	
DIA-SU4.2	*Partner with the Indiana University School of Optometry, the Indiana Optometric Association, and Prevent Blindness Indiana to promote annual eye examinations through local churches, community health centers, and minority health coalitions.*	
	Other Potential Strategies: *DIA-SU3.1*	
DIA-U5 HP2010 Ref: 5-14	Increase the proportion of adults with diabetes in Indiana's racial and ethnic populations who have at least an annual foot examination from X% of adults aged 18 years and older with diabetes (2000) to 75% (increase to HP2010 target).	• Total: 56.8% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: 56.3%
	Potential Strategies: *DIA-SU3.1* *DIA-SU4.1*	
DIA-U6 HP2010 Ref: 5-15	Increase the proportion of persons with diabetes in Indiana's racial and ethnic populations who have at least an annual dental examination from X% of persons aged 2 years and older with diabetes (2000) to 75% (increase to HP2010 target).	• Total: X % • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X%

		• White: X%
	Potential Strategies: *DIA-SU3.1* *DIA-SU4.1*	
DIA-U7 HP2010 Ref: 5-17	Increase the proportion of adults with diabetes in Indiana's racial and ethnic populations who perform self-blood glucose monitoring at least once daily from X% of adults aged 18 years and older with diabetes (2000) to 60% (increase to HP2010 target).	• Total: 51.9% • American Indian or Alaska Native: X% • Asian or Pacific Islander: X% • Black or African American: X% • Hispanic or Latino: X% • White: 53.0%
DIA-SU7.1	*Expand opportunities and venues (schools, work sites, communities) for racial and ethnic minorities in Indiana at risk for diabetes to receive formal education about risk factors, behavior modification, and effective self-care management.*	

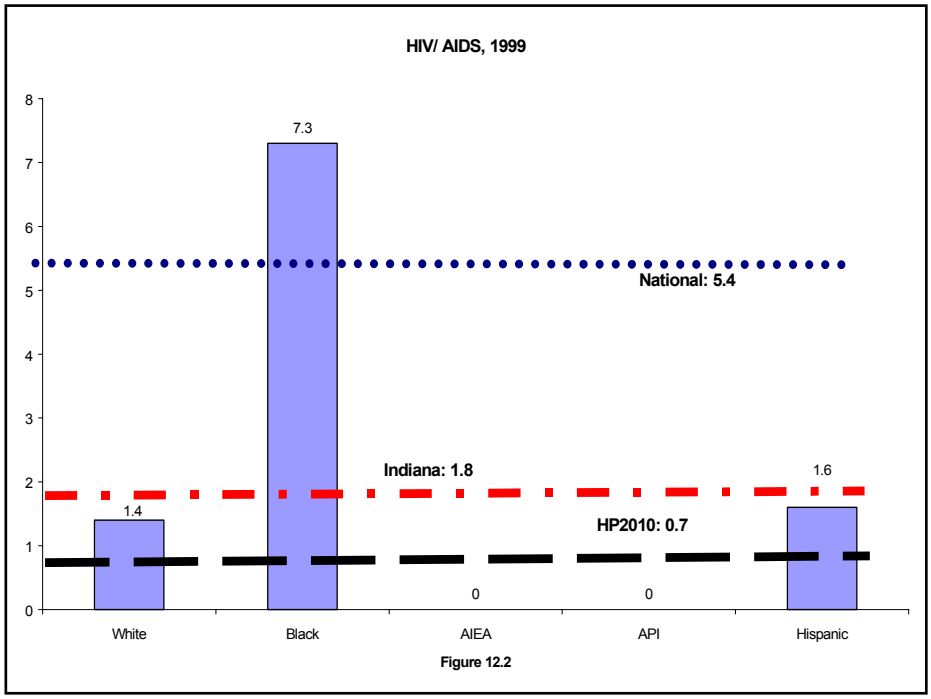
HIV/AIDS

RATIONALE



More than 700,000 cases of AIDS have been reported in the United States since 1981 and as many as 900,000 Americans may be infected with HIV. In 1999, HIV/AIDS caused 14,802 deaths in the U.S. Males have a higher rate of HIV/AIDS than women (8.4 per 100,000 males versus 2.6 per 100,000 females).

The impact of HIV/AIDS within minority communities has been devastating, especially among Black or African American males. It is estimated that 1 in 50 Black or African American men and 1 in 160 Black or African American women are infected with HIV. Blacks or African Americans accounted for 21,900 of the 46,400 total AIDS cases reported in the U.S. during 1999. The Hispanic or Latino population is growing and so are the numbers of reported HIV/AIDS cases. Hispanics or Latinos accounted for 18 percent (9,021) of the AIDS cases reported in 1999. Next in terms of impact are American Indians or Alaska Natives, followed by Asians or Pacific Islanders. It is important to note that even though the Asian or Pacific Islander community has smaller numbers, Asian or Pacific Islander women have a higher number of reported AIDS cases then Asian or Pacific Islander men.



Rates per 100,000 population (columns reflect Indiana data)

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – HIV/AIDS

Healthy People 2010 provides 17 objectives specific to HIV/AIDS. Of those 17 objectives, the most relevant to the purpose and objectives of the Healthy Indiana Minority Health Plan are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***. Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

HIV/AIDS OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
HIV-1 **HP2010 Ref: 13-1**	**Reduce the prevalence of HIV/AIDS among Indiana's Black or African American population from 416.6 cases of HIV/AIDS per 100,000 Black or African American persons (2002) to 250.0 cases of HIV/AIDS per 100,000 Black or African American persons (reduce to InMHAC target of 40% improvement).**	• **Total: 105.5 per 100,000** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 416.6 per 100,000** • **Hispanic or Latino: 131.9 per 100,000** • **White: 74.6 per 100,000**
HIV-2 **HP2010 Ref: 13-1**	**Reduce the prevalence of HIV/AIDS among Indiana's Hispanic or Latino population from 131.9 cases of HIV/AIDS per 100,000 Hispanic or Latino persons (2002) to 79.1 cases of HIV/AIDS per 100,000 Hispanic or Latino persons (reduce to InMHAC target of 40% improvement).**	• **Total: 105.5 per 100,000** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 416.6 per 100,000** • **Hispanic or Latino: 131.9 per 100,000** • **White: 74.6 per 100,000**
HIV-3 **HP2010 Ref: 13-1**	**Reduce the prevalence of AIDS among Indiana's Black or African American population from 346.6 cases of AIDS per 100,000 Black or African American persons (2002) to 232.2 cases of AIDS per 100,000 Black or African American persons (reduce to InMHAC target of 33% improvement).**	• **Total: 110.4 per 100,000** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: Data are not available** • **Black or African American: 346.6 per 100,000** • **Hispanic or Latino: 104.0 per 100,000** • **White: 88.4 per 100,000**
HIV-4 **HP2010 Ref: 13-1**	**Reduce the prevalence of AIDS among Indiana's Hispanic or Latino population from 104.0 cases of AIDS per 100,000 Hispanic or Latino persons**	• **Total: 110.4 per 100,000** • **American Indian or Alaska Native: Data are not available**

	(2002) to 69.7 cases of AIDS per 100,000 Hispanic or Latino persons (reduce to InMHAC target of 33% improvement).	• **Asian or Pacific Islander: Data are not available** • **Black or African American: 346.6 per 100,000** • **Hispanic or Latino: 104.0 per 100,000** • **White: 88.4 per 100,000**
HIV-S1.1 – HIV-S4.1	*Promote Indiana's "Get Tested" for HIV campaign and other HIV prevention interventions and public awareness campaigns to the top 11 populated cities of Indiana where HIV rates are the highest and where the percentages of racial and ethnic minority residents are the greatest (Indianapolis, Gary, South Bend, Fort Wayne, Evansville, Terre Haute, Anderson, Jeffersonville, Muncie, Kokomo, and Richmond).*	
HIV-S1.2 – HIV-S4.2	*Expand opportunities and venues to educate unmarried Black or African American and Hispanic or Latino persons on the necessity of practicing safe sex, including the importance of condom use and the complications illicit drugs and other STDs.*	
HIV-S1.3 – HIV-S4.3	*Expand opportunities and venues to provide Black or African American and Hispanic or Latino persons with education, testing, treatment, and prophylaxis consistent with current Public Health Service guidelines.*	
HIV-S1.4 – HIV-S4.4	*Increase funding for specific public health programs and interventions targeting Black or African American and Hispanic or Latino populations and communities.*	
HIV-S1.5 – HIV-S4.5	*Increase federal and state funding for care coordination services to accommodate more Black or African American and Hispanic or Latino persons with HIV/AIDS.*	
HIV-S1.6 – HIV-S4.6	*Provide capacity building training (e.g., cultural competency, strategic planning, etc.) to AIDS service organizations in Indiana to recognize and accommodate the growing population of Blacks or African Americans and Hispanics or Latinos with AIDS.*	

OBJECTIVES UNSUPPORTED BY INDIANA-SPECIFIC BASELINE DATA – HIV/AIDS

HIV/AIDS UNSUPPORTED OBJECTIVES AND *POTENTIAL STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE NOT AVAILABLE**
HIV-U1 HP2010 Ref: 13-2	Reduce the number of new AIDS cases among adolescent and adult Black or African American men who have sex with men from X new cases among Black or African American males aged 13 years and older (2000) to X new cases (HP2010 target of 25% improvement).	• Total: X new cases • American Indian or Alaska Native: X new cases • Asian or Pacific Islander: X new cases • Black or African American: X new cases • Hispanic or Latino: X new cases • White: X new cases
	Potential Strategies:	

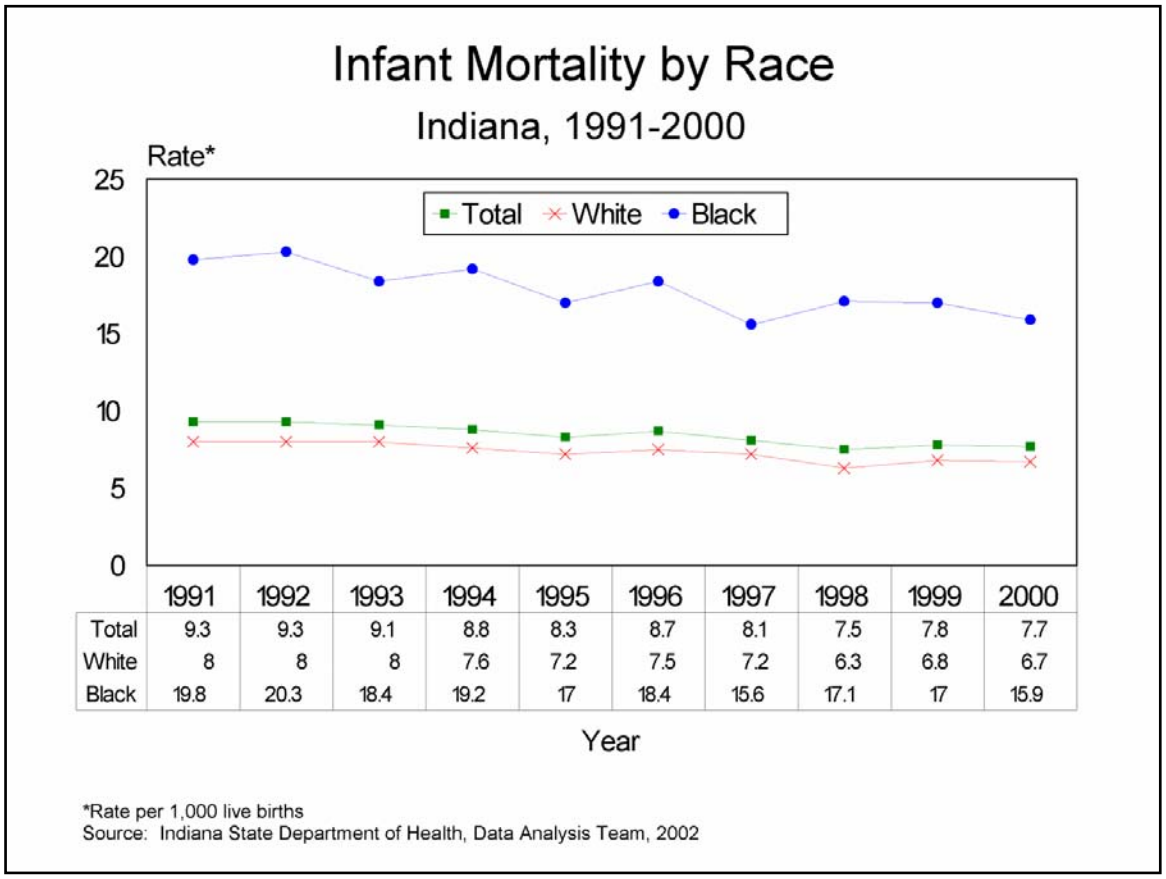
HIV-U2 HP2010 Ref: 13-3	Reduce the number of new AIDS cases among Black or African American females and males who inject drugs from X new cases of AIDS among Black or African American injection drug users aged 13 years and older (2000) to X new cases (HP2010 target of 25% improvement).	• Total: X new cases • American Indian or Alaska Native: X new cases • Asian or Pacific Islander: X new cases • Black or African American: X new cases • Hispanic or Latino: X new cases • White: X new cases
	Potential Strategies:	

INFANT MORTALITY

RATIONALE

Infant mortality is a key indicator of the health and well-being of a community, whether it is a country, state, city, or neighborhood. The United States ranks 26th in the world in infant mortality with a 1999 infant mortality rate (IMR) of 7.0 per 1,000 live births. There were 18,728 neonatal deaths (4.7 per 1,000 live births) and 9,209 post-neonatal deaths (2.3 per 1,000 live births) in the U.S. in 1999.

Indiana ranks 15th nationally in infant mortality with a rate of 7.8 per 1,000 live births. In an average Indiana week, 1,605 babies are born. Of those, 223 are born to teen mothers, 61 are born to mothers who received late or no prenatal care, 123 are born at low birth weight (<5.5 lbs.), 21 are born at a very low birth weight (<3.3 lbs.), and 13 die before their first birthday.



	1991	1992	1993	1994	1995	1996	1997	1998	1999	2000
Total	9.3	9.3	9.1	8.8	8.3	8.7	8.1	7.5	7.8	7.7
White	8	8	8	7.6	7.2	7.5	7.2	6.3	6.8	6.7
Black	19.8	20.3	18.4	19.2	17	18.4	15.6	17.1	17	15.9

Blacks or African Americans have the highest infant mortality rate. The National Center for Health Statistics (NCHS) reports a Black or African American IMR of 14.6 per 1,000 per live births. Indiana's Black or African American IMR is 17.0 per 1,000 live births, more than double the rate for Indiana's Hispanics or Latinos (7.1/1,000) and Whites (6.8/1,000). Blacks or African Americans also are ranked the highest in neonatal deaths at 9.8 per 1,000 live births. The NCHS national rates for post-neonatal deaths show similar rates for Blacks or African Americans and American Indians or Alaska Natives at 4.8 per 1,000 live births and 3.8 per 1,000 live births, respectively.

The availability and adequacy of prenatal care during the first trimester are significant factors influencing risk for pre-term delivery, low birth-weight, and other complications of pregnancy which produce higher rates of infant, neonatal, and post-neonatal mortality.

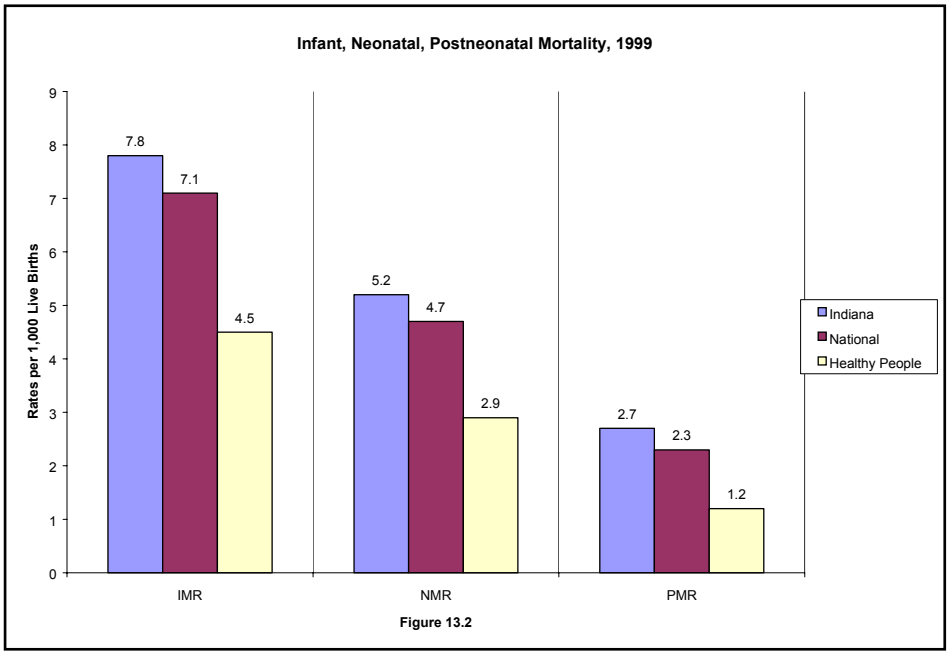


Figure 13.2

Rates per 100,000 population (columns reflect Indiana data)

OBJECTIVES, STRATEGIC ACTIONS, AND INTERVENTIONS – INFANT MORTALITY

Healthy People 2010 provides 21 objectives specific to perinatal care. Of those 17 objectives, the most relevant to the purpose and objectives of the Healthy Indiana Minority Health Plan are listed in the Appendix. Based on the *Healthy People 2010* objectives, the following objectives are being proposed under the Healthy Indiana Minority Health Plan as ***Healthy Indiana Minority Health 2010 Objectives***. Strategic actions and interventions have been developed specifically to address the Healthy Indiana Minority Health Objectives listed below:

INFANT MORTALITY OBJECTIVES AND *STRATEGIC ACTIONS/INTERVENTIONS*		**INDIANA BASELINE**
IMR-1 **HP2010 Ref: 16-1c**	**Reduce infant deaths (within 1 year) among Indiana's Black or African American population from 15.9 per 1,000 live births (2000) to 6.7 per 1,000 live births (reduce to rate for Indiana White population).**	• **Total: 7.7 per 1,000** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: 5.1 per 1,000** • **Black or African American: 15.9 per 1,000** • **Hispanic or Latino: 5.2 per 1,000** • **White: 6.7 per 1,000**

IMR-S1.1	*Expand opportunities and venues to provide early and adequate prenatal care beginning in the first trimester of pregnancy to Black or African American females.*	
IMR-S1.2	*Continue to promote the Health Baby Showers in cities with the highest prevalence of Black or African American infant mortality deaths (e.g., Evansville, Gary, Indianapolis, and South Bend).*	
IMR-S1.3	*Continue to promote the "Baby First" campaign in cities with the highest prevalence of Black or African American infant mortality deaths (e.g., Evansville, Gary, Indianapolis, and South Bend).*	
IMR-S1.4	*Create effective and coordinated operational linkages between services available to Black or African American females (e.g., Women, Infants, and Children (WIC) programs, community health centers, minority health coalitions, Prenatal Substance Abuse Prevention Programs (PSUPP) (if needed), tobacco cessation programs (if needed), local Medicaid offices, and community nutrition).*	
IMR-S1.5	*Promote Indiana's 2-1-1 system for social services within Black or African American communities.*	
IMR-S1.6	*Promote the Indiana State Department of Health's and Indiana Minority Health Coalition's Helpline for local prenatal care services within Black or African American communities.*	
IMR-S1.7	*Increase the number and effectiveness of outreach workers in areas with highest prevalence of Black or African American infant mortality deaths (e.g., Evansville, Gary, Indianapolis, and South Bend).*	
IMR-S1.8	*Promote the Indiana Perinatal Network (IPN) Back To Sleep and Baby First campaigns within Black or African American communities.*	
IMR-S1.9	*Create educational programs for physicians, hospitals and staff on the issues surrounding Black or African American infant mortality.*	
IMR-S1.10	*Continue to provide culturally appropriate education on reducing Black or African American infant deaths from complications of sexually transmitted diseases (STDs), poor oral hygiene education, stress, lack of prenatal appointments, substance abuse, alcohol and tobacco use, domestic violence, and poor nutrition.*	
IMR-S1.11	*Link Black or African American women into Indiana Title X family planning clinics.*	
IMR-2 **HP2010 Ref: 16-10a**	**Reduce low birth weight (LBW) among Indiana's Black or African American population from 12.7% of live births (2000) to 6.7% of live births (reduce to percent for Indiana White population).**	• **Total: 7.3%** • **American Indian or Alaska Native: 2.6%** • **Asian or Pacific Islander: 7.3%** • **Black or African American: 12.7%** • **Hispanic or Latino: 5.3%** • **White: 6.7%**
IMR-3 **HP2010 Ref: 16-10a**	**Reduce low birth weight (LBW) among Indiana's Asian or Pacific Islander population from 7.3% of live births (2000) to 6.7% of live births (reduce to percent for Indiana White population).**	• **Total: 7.3%** • **American Indian or Alaska Native: 2.6%** • **Asian or Pacific Islander: 7.3%**

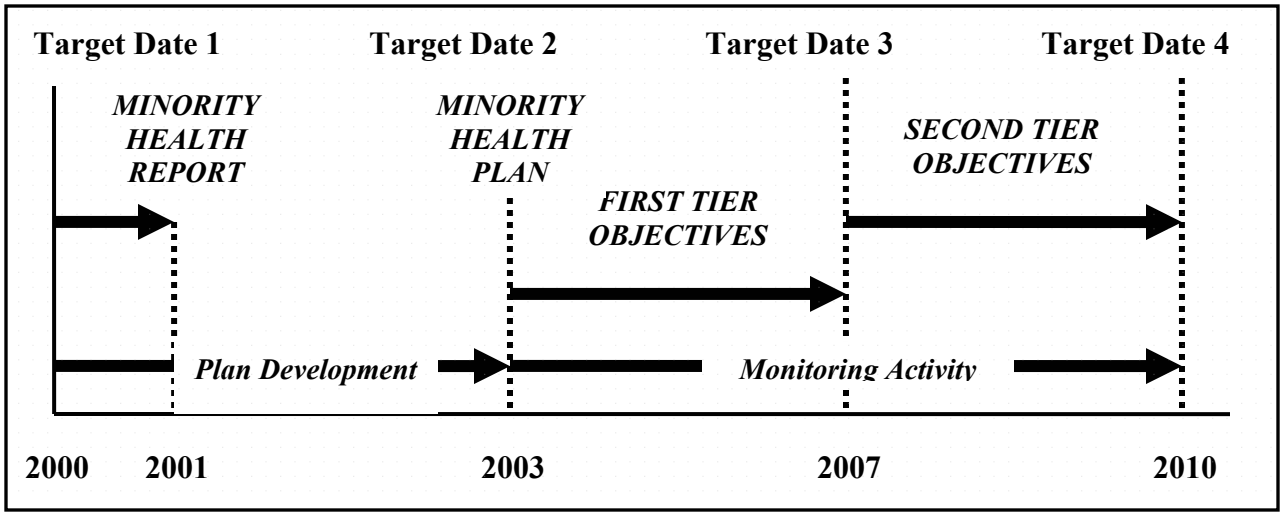
		• **Black or African American: 12.7%** • **Hispanic or Latino: 5.3%** • **White: 6.7%**
IMR-S2.1 – IMR-S3.1	*Educate Asian or Pacific Islander and Black or African American women on the factors and conditions that can lead to low-birth weight babies (e.g., stress, alcohol, tobacco use, drug- use, STD's and nutrition).*	
IMR-S2.2 – IMR-S3.2	*Enroll more expectant Asian or Pacific Islander and Black or African American mothers into Indiana's WIC, Healthy Start, and Prenatal Substance Abuse Prevention Program (PSUPP).*	
IMR-S2.3 – IMR-S3.3	*Provide incentives for expectant Asian or Pacific Islander and Black or African American mothers to use the WIC vouchers at Indiana's Farmers markets.*	
IMR-S2.4 – IMR-S3.4	*Target interventions for prenatal care in communities where Asian or Pacific Islander and Black or African American infant mortality rates are the highest.*	
IMR-S2.5 – IMR-S3.5	*Highlight the Indiana Baby First program and Indiana Perinatal Network and link the two interventions to create a public awareness campaign in the Asian or Pacific Islander and Black or African American communities.*	
IMR-S2.6 – IMR-S3.6	*Create an awareness and educational program to reach out to expectant Asian or Pacific Islander and Black or African American fathers regarding the importance of prenatal visits.*	
IMR-S2.7 – IMR-S3.7	*Utilize community outreach workers to educate Asian or Pacific Islander and Black or African American women about the importance of proper nutrition.*	
IMR-S2.8 – IMR-S3.8	*Assist communities in solving transportation problems for Asian or Pacific Islander and Black or African American persons needing transport to prenatal appointments.*	
IMR-S2.9 – IMR-S3.9	*Educate Asian or Pacific Islander and Black or African American women on the importance of child spacing and the family planning services and practices available to them.*	
IMR-4 **HP2010 Ref: 16-10b**	**Reduce very low birth weight (VLBW) among Indiana's Black or African American population from 2.9% of live births (2000) to 1.2% of live births (reduce to percent for Indiana White population).**	• **Total: 1.4%** • **American Indian or Alaska Native: Data are not available** • **Asian or Pacific Islander: 0.5%** • **Black or African American: 2.9%** • **Hispanic or Latino: 1.0%** • **White: 1.2%**
IMR-S4.1	*Incorporate prenatal care programs (e.g., WIC, PSUPP, etc.) into community health centers and remove the barriers that prevent Black or African American females from accessing prenatal services.*	
IMR-S4.2	*Create within Black or African American communities awareness campaigns regarding sexually transmitted diseases (STDs) and their complications in pregnancy.*	
IMR-S4.3	*Provide more education to Black or African American females on oral hygiene and its relationship to very low birth weight babies.*	

IMR-S4.4	*Develop a curriculum for Black or African American females that incorporates a stress program and relaxation techniques into prenatal visits.*
IMR-S4.5	*Enroll more expectant Black or African American mothers into lifestyle changing programs (e.g., Prenatal Substance Abuse Prevention Program (PSUPP), smoking cessation programs, nutrition programs, and breastfeeding programs).*

ACTION PLAN

PRIORITY OBJECTIVES, STRATEGIES, AND INTERVENTIONS

Objectives, strategies, and interventions are stratified according to perceived importance relative to burden of risk and potential for preventing morbidity, disability, and/or mortality. Those most compelling, indicating significant gap effects and requiring necessary and immediate action, are listed as first tier priorities with the following timeline. The others exist as second tier priorities.



FOCUS AREA	TARGETED PRIORITY OF FIRST TIER OBJECTIVES			
	American Indian or Alaska Native	Asian or Pacific Islander	Black or African American	Hispanic or Latino
Workforce Diversity	●		●	●
Cultural and Linguistic Competency	●	●	●	●
Heart Disease			●	●
Cancer			●	
Stroke			●	●
Asthma			●	
Diabetes			●	●
HIV/AIDS			●	●
Infant Mortality		●	●	

SUMMARY OF FIRST TIER OBJECTIVES, STRATEGIES, AND INTERVENTIONS				
HEALTHY INDIANA MINORITY HEALTH 2010 FIRST TIER OBJECTIVE		**INDIANA 2000 BASELINE**	**INDIANA BENCHMARKS**	**INDIANA 2010 TARGET**
WFD-1 – WFD-7	In allied health, nursing, medicine, dentistry, pharmacy, optometry, and public health, increase the proportion of all degrees awarded to American Indians or Alaska Natives, Blacks or African Americans, and Hispanics or Latinos.	Current levels.	Total: See chart White: See chart Basis: % population	Proportionate to levels comparable to their respective proportions in the Indiana population.
CLC-1	Improve data monitoring and evaluation of programs and efforts to enhance cultural competency in health care.	N/A	Total: N/A White: N/A Basis: Best practice	Best practice.
CLC-4	Promote a culturally and linguistically competent system of health care that acknowledges and incorporates all levels of importance of culture and language, the cultural strengths associated with people and communities, and the assessment of cross-cultural relations.	N/A	Total: N/A White: N/A Basis: Best practice	Best practice.
CLC-5	Promote better understanding of strategies on how to serve diverse populations.	N/A	Total: N/A White: N/A Basis: Best practice	Best practice.
CLC-6	Reduce access to care barriers that foster racial and ethnic disparities in health.	N/A	Total: N/A White: N/A Basis: Best practice	Best practice.
CLC-8	Reduce systemic barriers that impact structure, logistics, and processes of care and foster racial and ethnic disparities in health.	N/A	Total: N/A White: N/A Basis: Best practice	Best practice.

CLC-9	Reduce provider-based barriers that impact health care encounters, provider-patient communication and foster racial and ethnic disparities in health.	N/A	Total: N/A White: N/A Basis: Best practice	Best practice.
CVD-1	Reduce coronary heart disease deaths among Indiana's Black or African American population.	243.5 coronary heart disease deaths per 100,000 Black or African American persons (2000).	Total: 203.6 per 100,000 White: 203.1 per 100,000 Basis: InMHAC (30% improvement)	170.5 coronary heart disease deaths per 100,000 Black or African American persons.
CVD-3 STR-3	Reduce the proportion of adults among Indiana's Black or African American population with high blood pressure.	35.6% of Black or African American adults aged 20 years and older (2001).	Total: 25.7% White: 25.2% Basis: HP2010	16.0% of Black or African American adults aged 20 years and older.
CVD-7 STR-7	Increase the proportion of adults among Indiana's Hispanic or Latino population who have had their blood cholesterol checked within the preceding 5 years.	53.1% of Hispanic or Latino adults aged 18 years and older (2001).	Total: 69.9% White: 70.2% Basis: InMHAC	85.0% of Hispanic or Latino adults aged 18 years and older.
CAN-1	Reduce the overall cancer death rate among Indiana's Black or African American population.	274.9 cancer deaths per 100,000 Black or African American persons (2000).	Total: 221.9 per 100,000 White: 221.5 per 100,000 Basis: InMHAC (30% improvement)	192.4 cancer deaths per 100,000 Black or African American persons.
CAN-2	Reduce the lung and bronchus cancer death rate for males among Indiana's Black or African American population.	110.7 lung and bronchus cancer deaths per 100,000 Black or African American males (2000).	Total: 94.4 per 100,000 males White: 94.8 per 100,000 males Basis: HP2010 (22% improvement)	86.3 lung and bronchus cancer deaths per 100,000 Black or African American males.
CAN-3	Reduce the lung and bronchus cancer death rate for females among Indiana's Black or African American population.	53.7 lung and bronchus cancer deaths per 100,000 Black or African American females (2000).	Total: 49.4 per 100,000 females White: 49.7 per 100,000 females Basis: HP2010 (22% improvement)	41.9 lung and bronchus cancer deaths per 100,000 Black or African American females.

CAN-4	Reduce the breast cancer death rate for females among Indiana's Black or African American population.	39.9 breast cancer deaths per 100,000 Black or African American females (2000).	Total: 28.8 per 100,000 females White: 28.4 per 100,000 females Basis: HP2010 (20% improvement)	31.9 breast cancer deaths per 100,000 Black or African American females.
CAN-6	Reduce the death rate from cancer of the uterine cervix among Indiana's Black or African American population.	4.9 cervical cancer deaths per 100,000 Black or African American females (2000).	Total: 3.1 per 100,000 females White: 3.1 per 100,000 females Basis: HP2010 (33% improvement)	3.3 cervical cancer deaths per 100,000 Black or African American females.
CAN-8	Reduce the colorectal cancer death rate for males among Indiana's Black or African American population.	42.9 colorectal cancer deaths per 100,000 Black or African American males (2000).	Total: 28.6 per 100,000 males White: 28.1 per 100,000 males Basis: HP2010 (34% improvement)	28.3 colorectal cancer deaths per 100,000 Black or African American males.
CAN-9	Reduce the colorectal cancer death rate for females among Indiana's Black or African American population.	21.4 colorectal cancer deaths per 100,000 Black or African American females (2000).	Total: 20.2 per 100,000 females White: 18.6 per 100,000 females Basis: HP2010 (34% improvement)	14.1 colorectal cancer deaths per 100,000 Black or African American females (reduce to HP2010 target of 34% improvement).
CAN-10	Increase the proportion of adults among Indiana's Black or African American population who receive a colorectal cancer screening examination.	38.7% of Black or African American adults aged 50 years and older who have ever received sigmoidoscopy (2001).	Total: 44.7% White: 45.1% Basis: HP2010	50.0% of Black or African American adults aged 50 years and older who have ever received sigmoidoscopy.
CAN-11	Reduce the prostate cancer death rate among Indiana's Black or African American population.	73.9 prostate cancer deaths per 100,000 Black or African American males (2000).	Total: 31.4 per 100,000 males White: 29.3 per 100,000 males Basis: InMHAC (40% improvement)	44.3 prostate cancer deaths per 100,000 Black or African American males.
CAN-12	Reduce the oropharyngeal cancer death rate among Indiana's Black or African American population.	5.1 oropharyngeal cancer deaths per 100,000 Black or African American persons (2000).	Total: 2.6 per 100,000 White: 2.4 per 100,000 Basis: InMHAC	3.1 oropharyngeal cancer deaths per 100,000 Black or African American persons.

			(40% improvement)	
STR-1	Reduce stroke deaths among Indiana's Black or African American population.	92.3 stroke deaths per 100,000 Black or African American persons (2000).	Total: 74.0 per 100,000 White: 73.3 per 100,000 Basis: InMHAC (40% improvement)	55.4 stroke deaths per 100,000 Black or African American persons.
AST-1	Reduce asthma deaths among Indiana's Black or African American population.	6.3 asthma deaths per 100,000 Black or African American persons (2000).	Total: 1.4 per 100,000 White: 1.0 per 100,000 Basis: InMHAC (40% improvement)	3.8 asthma deaths per 100,000 Black or African American persons.
DIA-1	Reduce the prevalence of diabetes among Indiana's Black or African American population.	53.0 cases of diabetes per 1,000 Black or African American persons (1999).	Total: 45.0 per 1,000 White: 45.3 per 1,000 Basis: InMHAC (50% improvement)	26.5 cases of diabetes per 1,000 Black or African American persons.
DIA-2	Reduce the diabetes death rate among Indiana's Black or African American population.	57.4 diabetes deaths per 100,000 Black or African American persons (2000).	Total: 29.0 per 100,000 White: 27.5 per 100,000 Basis: InMHAC (50% improvement)	28.7 diabetes deaths per 100,000 Black or African American persons.
DIA-3	Reduce the diabetes death rate among Indiana's Hispanic or Latino population.	51.7 diabetes deaths per 100,000 Hispanic or Latino persons (2000).	Total: 29.0 per 100,000 White: 27.5 per 100,000 Basis: InMHAC (50% improvement)	25.9 diabetes deaths per 100,000 Hispanic or Latino persons.
HIV-1	Reduce the prevalence of HIV/AIDS among Indiana's Black or African American population.	416.6 cases of HIV/AIDS per 100,000 Black or African American persons (2002).	Total: 105.5 per 100,000 White: 74.6 per 100,000 Basis: InMHAC (40% improvement)	250.0 cases of HIV/AIDS per 100,000 Black or African American persons.
HIV-2	Reduce the prevalence of HIV/AIDS among Indiana's Hispanic or Latino population.	131.9 cases of HIV/AIDS per 100,000 Hispanic or Latino persons (2002).	Total: 105.5 per 100,000 White: 74.6 per 100,000 Basis: InMHAC	79.1 cases of HIV/AIDS per 100,000 Hispanic or Latino persons (InMHAC target of 40% improvement).

			(40% improvement)	
HIV-3	Reduce the prevalence of AIDS among Indiana's Black or African American population.	346.6 cases of AIDS per 100,000 Black or African American persons (2002).	Total: 110.4 per 100,000 White: 88.4 per 100,000 Basis: InMHAC (33% improvement)	232.2 cases of AIDS per 100,000 Black or African American persons (InMHAC target of 33% improvement).
IMR-1	Reduce infant deaths (within 1 year) among Indiana's Black or African American population.	15.9 per 1,000 live births (2000).	Total: 7.7 per 1,000 White: 6.7 per 1,000 Basis: InMHAC (equal to Indiana White rate)	6.7 per 1,000 live births.
IMR-2	Reduce low birth weight (LBW) among Indiana's Black or African American population.	12.7% of live births (2000).	Total: 7.3% White: 6.7% Basis: InMHAC (equal to Indiana White rate)	6.7% of live births.
IMR-3	Reduce low birth weight (LBW) among Indiana's Asian or Pacific Islander population.	7.3% of live births (2000).	Total: 7.3% White: 6.7% Basis: InMHAC (equal to Indiana White rate)	6.7% of live births.
IMR-4	Reduce very low birth weight (VLBW) among Indiana's Black or African American population.	2.9% of live births (2000).	Total: 1.4% White: 1.2% Basis: InMHAC (equal to Indiana White rate)	1.2% of live births.

PUBLIC POLICY RECOMMENDATIONS

1. Ensure that ISDH funding criteria reflect the special needs of priority communities by linking ISDH grants programmatically to the Healthy Indiana Minority Health 2010 objectives and requiring grantees as a point of eligibility to identify which HIMH2010 objectives are being targeted in the grant proposal and included as part of the outcome and impact evaluation scheme.
2. Establish Minority Health Month in Indiana as a permanent health theme for April each year to help raise awareness of the problem of racial and ethnic health disparities and to foster activity and generate partnerships to prevent, treat, control, and eliminate conditions that lead to racial and ethnic health disparities.
3. Establish and support through legislation and funding authorization an external Racial and Ethnic Minority Epidemiology Center as a new data source that will collaborate with the ISDH Epidemiology Resource Center and Surveillance Investigation Unit to: (a) focus on relevant disease areas, related health issues and trends, and the environmental and socioeconomic conditions that contribute to racial and ethnic health disparities; (b) establish a comprehensive and integrated health data collection system and registry on health care outcomes, the adequacy and quality of services, the relationship between quality of life measures and health care treatment, and the availability of culturally and linguistically appropriate provider-patient interactions by racial and ethnic classification and community, city, and county of residence; and (c) analyze and report health related data on racial and ethnic minorities in Indiana.
4. Establish with representation from state, local, community and private agencies, and organizations and academic institutions actively involved and participating in efforts to eliminate racial and ethnic health disparities and improve minority health an interagency (super) committee to oversee disease surveillance, review health status indicators, evaluate demographic changes, assess barriers to health care, communicate data, share information across programs, and monitor progress toward the elimination or racial and ethnic health disparities in Indiana.
5. Establish legislative policies that direct state officials to finds ways to ensure equal access to financial coverage of health care services for all Indiana residents irrespective of employment, income, or health status.
6. Establish, through legislative mandates, statewide policies that direct state and local public school authorities to address issues of nutrition in their cafeteria and vending machines by providing nutritious alternative food supplies, such as low-fat yogurt, fruits, vegetables, salads, granola bars, juice, and milk.
7. Establish, through legislative mandates, statewide policies that direct state and local public school authorities to address issues of physical fitness by implementing in their curricula, at a minimum, the national guidelines for the amount of minutes per week that should be devoted to physical fitness (e.g., 150 minutes per week for elementary school children, 225 minutes per week for middle school and high school students).

8. Establish and operate school-based clinics and/or school nurse programs in public primary and secondary schools with high enrollments of racial and ethnic minority students to provide opportunity for timely access to appropriate health care services.
9. Partner with the corporate community to make available to employees worksite-based clinics and on-site health care services so that employees will not have to take time off from work and risk losing income for time missed for necessary health services.
10. Develop and implement state health care purchasing strategies that support extended opportunities for eliminating racial and ethnic health disparities.
11. Establish a Health Professions Scholarship Fund to recruit underrepresented racial and ethnic minority students in Indiana into the health professions and financially support their education in qualified health professions schools and programs.
12. Develop criteria for defining local racial and ethnic minority health professional shortage areas (MHPSA) based on the ratio of racial and ethnic minority health professionals practicing per capita of racial and ethnic minority residents in the community.
13. Create and expand financial reimbursement incentives, loan forgiveness programs, practice development activities, and other professional inducements to encourage, motivate, and support racial and ethnic minority health professionals to come to, return to, and/or stay in Indiana and practice in communities that satisfy the criteria for racial and ethnic minority health professional shortage area (MHPSA) designation.
14. Provide reimbursement mechanisms to cover the direct and indirect cost of patient education and counseling with regard to diet, exercise, and other lifestyle modifications necessary for improving the health of racial and ethnic minority populations.

ISDH PROGRAM DEVELOPMENT AND/OR EXPANSION RECOMMENDATIONS

1. Issue an ISDH "Call to Action" on health disparities and assume the lead role in planning, developing, implementing, and evaluating programs and strategies to eliminate racial and ethnic health disparities in Indiana.
2. Expand the ISDH Epidemiology Resource Center and Surveillance Investigation Unit. Establish through legislation and funding an external Racial and Ethnic Minority Epidemiology Center as a new data source that will focus efforts on the seven identified disease focus areas, related health issues, and the environmental and socioeconomic conditions that contribute to racial and ethnic health disparities in Indiana.
3. Produce and release to the public on a biennial basis an Indiana Minority Health Report and Chart Book to document and assess changes in a standardized set of health status indicators among racial and ethnic minorities in Indiana.
4. Conduct, in conjunction with county health departments and local community-based and tribal organizations, a series of community/county-focused town meetings or summits to: 1) coincide with the release of the biennial Indiana Minority Health Report and Chart Book; 2) provide "state of the state" or "state of the community/county" forums for presenting and discussing significant findings, trends, and changes in the Report and/or Chart Book; and 3) generate local community input and investment in the adoption and implementation of new ISDH recommendations and strategies designed to meet the health needs of the community I eliminating racial and ethnic health disparities.
5. Develop and implement through the Office of Cultural Diversity and Enrichment state grant and contract requirements that address cultural and linguistic barriers and ensure compliance with core cultural competencies among all recipients of ISDH grants and contracts.
6. Provide periodic technical assistance workshops for minority community-based and tribal organizations to elevate their level of understanding of federal, state, and private grant application processes, evaluation requirements, and data reporting schemes, and to enhance their competitiveness for eligible public and private grants from state and national sponsors.
7. Implement a grant and contract review and approval process that considers the infrastructure and capability of the applicant to produce the requested deliverables. Applicants should demonstrate cultural and linguistic competency, access to the target population, and representation of racial and ethnic minorities.
8. Partner with and/or support minority community-based and tribal organizations and colleges and universities in responding to grant announcements from the U.S. Office of Minority Health. Strengthen local efforts to apply for grants by assisting minority-serving groups working in communities highly affected by HIV/AIDS, cancer, diabetes, and other issues for which there are documented health disparities: *Health Disparities in Minority Health Grants* (reducing high risk behavior, improving access to health care, addressing HIV/AIDS), *Minority Community Health Coalition Demonstration Grants, HIV* (increasing community understanding of HIV/AIDS and improving access to services), *State and Territorial Minority HIV/AIDS Demonstration Grants* (demonstrating the role of state office of minority health in coordinating statewide responses to HIV/AIDS), and *Technical Assistance and Capacity Development Grants for HIV/AIDS* (developing effective and durable service

delivery among minority-serving organizations involved in HIV/AIDS prevention and treatment).

9. Develop and distribute personal health profile forms (e.g., lifestyle, height; weight; blood pressure; serum cholesterol, blood glucose, and triglyceride levels; exam history; etc.) and action plan worksheets (e.g., walking, exercise, weight management, nutritional counseling, diet modification, smoking cessation, and other health seeking behavior programs) to racial and ethnic minority populations to support chronic disease self management and promote "personal responsibility for health."
10. Ensure that every racial and ethnic minority patient receives appropriate and timely assessments of lifestyle, body mass index, blood pressure, cholesterol, blood glucose, and triglyceride levels, and that each patient records the results of his or her assessment on their personal health profile form as a way to expand opportunities for identifying undiagnosed cases and persons at risk for chronic disease and assist the public in understanding the significance of their clinical findings and the importance of acknowledging, monitoring and managing their health status.
11. Increase opportunities through outreach activities within racial and ethnic populations to screen and provide follow-up therapeutic interventions for elevated blood pressure, cholesterol, blood glucose, and triglyceride levels.
12. Create a special committee composed of representatives from the Indiana Minority Health Advisory Committee, the Indiana Health Care Professional Development Commission, the Indiana Career and Post-secondary Advancement Center, the Indiana Higher Education Commission, the Interagency State Council on Black and Minority Health, the Indiana Minority Health Coalition, the Indiana Latino Institute, the American Indian Center of Indiana, and the Governor's Native American Council to: 1) explore ideas for expanding the pool of racial and ethnic minorities in the health professions; 2) search for funding to support outreach and recruitment efforts; and 3) periodically assess the provider infrastructure by the number and geographic distribution of providers, areas of practice specialty, and competency in cultural and linguistic diversity.
13. Contract with the DHHS Region V Office of Minority Health to plan and conduct a Midwest Regional Conference on Racial and Ethnic Health Disparities and demonstrations of models and best practices for their elimination.

HEALTH SERVICES RECOMMENDATIONS

1. Develop programs to consistently educate and inform health care providers, patients, and payers on the efficacy and challenges of various methods of intervention and evidence-based disease management within diverse populations.
2. Integrate and institutionalize minimum standards of education for culturally and linguistically appropriate services (e.g. National Standards for Culturally and Linguistically Appropriate Services in Health Care from the U.S. Office of Minority Health) throughout the curricula of the state's health professions schools, academic programs, and institutions and into the continuing professional education programs of all state licensed health professions so that future and current health care practitioners, programs, and institutions will understand the meaning of cultural competency, their obligation to deliver culturally competent care, and methods for delivering culturally competent care to diverse patient populations.
3. Develop and distribute freely to health care providers, educators, social workers, counselors, and residents a community health resource/information clearing house list and description of all health care resources, provider services, and support networks available to community residents (e.g., SCHIP, cancer screening, Indian Health Service clinics, etc.), along with a directory of local speakers to talk on related topics (e.g., AIDS awareness, immunizations, etc.).
4. Increase the number and/or service areas of community and rural health centers, Indian Health Service clinics, and provider services to better accommodate the preventive, acute and chronic health needs of the communities they serve and provide better coordination of care in preventing and managing acute and chronic diseases.
5. Encourage the state's health professions schools to expand outreach clinic services to underserved minority communities with an effort to provide culturally related clinical training opportunities for students and necessary and appropriate care for community residents.
6. Partner with the Indiana Department of Education and the state's K-12 and higher educational institutions to develop, implement, expand, and strengthen career development programs, inter-institutional pipelines, mentoring programs, summer institutes, student tracking mechanisms, and other arrangements designed to identify, attract, and increase the number of racial and ethnic minority students in the state's health professions schools and academic programs.
7. Encourage the state's health professions schools and academic programs to more aggressively recruit and hire faculty that are representative of Indiana's racial and ethnic minority populations and increase their percentages to levels comparable to their respective percentage in the Indiana population.
8. Expand clinical practice opportunities and student externships in formal health education and social work programs to facilitate the use of undergraduate and graduate students in patient and caregiver education, outreach, and follow-up regarding health related behavior and compliance.

9. Encourage the Indiana University School of Medicine Department of Public Health to identify racial and ethnic health disparities as a major area of academic, clinical, and research focus for its faculty and graduate students in the Master of Public Health (M.P.H.) program and to use its consortium of academic schools and departments to establish an academic Center of Excellence for the elimination or racial and ethnic health disparities in Indiana.

HEALTH PROMOTION AND COMMUNICATION STRATEGIES RECOMMENDATIONS

1. Establish minority health liaisons in each major division of state government to serve as conduits of information and communication, to establish and maintain a minority health focus, and to adopt and integrate across agencies programs and activities to eliminate health disparities.
2. Establish minority health liaisons at each of the state's health professions schools and academic programs to form a collegial network of interdisciplinary faculty and staff that would promote the continuing development, implementation, and evaluation of programs and activities to eliminate racial and ethnic health disparities.
3. Establish community and tribal health liaisons in every racial and ethnic minority community to serve as cultural, linguistic, religious, and social bridges of knowledge, trust, support, and engagement to the community for local health departments, clinics, health care providers, and minority coalitions and as persons of reference for community-focused models that build capacity in the dissemination of information, provision of assistance and guidance, and mobilization of efforts regarding health related behavior.
4. Promote the development of local level partnerships with the public health community for community-based strategic assessment, planning and goal-setting using recognized tools such as MAPP (Mobilizing for Action through Planning and Partnerships).
5. Engage the media, communication, and advertising industries and sponsors to help with social marketing efforts, awareness campaigns, and communication of disease prevention and health promotion strategies, activities, and practices to racial and ethnic populations in Indiana.
6. Engage groceries, pharmacies, fast-food restaurants, barber and beauty shops, bowling alleys, police and fire departments, housing authorities, faith-based organizations, community-based organizations, tribal organizations, YMCAs, Boys' and Girls' Clubs, and other community relevant venues with high traffic of racial and ethnic minority populations and provide them with effective tools in efforts to foster social environments and networks that peer educate and peer promote healthy lifestyles and healthy behavior through venue-specific disease prevention and health promotion events and programs, such as the faith-based interventions promoted through "High Blood Pressure Sundays" and "Healthy Baby Sundays."
7. Encourage local hospitals, community health centers, and health care professionals to sponsor and/or host community-centered health fairs that provide no or low cost health screenings, enrollment outreach for Hoosier Healthwise, SCHIP, and other state administered health programs, and health promotion and preventive care information for uninsured residents.

PUBLIC/PRIVATE/COMMUNITY PARTNERSHIPS RECOMMENDATIONS

1. Continue and expand industry and public health forums and workshops to jointly focus and maintain attention on the economic and development impact of racial and ethnic health disparities and to strengthen the engagement of the corporate community in efforts to eliminate health disparities in Indiana.
2. Encourage each major corporate entity in Indiana as part of a "win-win" effort to adopt at least one of the Plan's seven identified disease focus areas and concentrate work site wellness programs and activities (e.g., providing employees with flexible schedules to allow time for exercise during lunch breaks) on improving associated health indicators (e.g., obesity) among its racial and ethnic employee population.
3. Encourage each major corporate entity in Indiana as part of a "win-win" effort to adopt a high health risk racial or ethnic neighborhood community and in conjunction with Chambers of Commerce, community health centers, community-based organizations and ISDH departments periodically sponsor awareness campaigns, education and intervention programs, neighborhood health fairs, culturally sensitive nutrition education seminars, and other community health events and health related activities designed to improve the health status of community residents.
4. Partner with the food industry, including food growers and farmer's markets, to provide coupons for discounts on vegetables and other healthy foods for highly at-risk and economically vulnerable racial and ethnic minority populations.
5. Partner with the restaurant industry to clearly label low-fat menu options and provide discounts on half-portion orders.
6. Develop and expand community-level partnerships with community and civic-based organizations, faith-based communities, social service agencies, tribal organizations, local business entities, professional sports corporations, county health departments, local health providers, community leaders, insurers, media, voluntary agencies, and philanthropic groups to facilitate outreach to "yet to be reached" and "hardly reached" priority populations, market health promotion and disease prevention strategies, implement health-related activities, communicate health education messages, and distribute information and materials on health resources available to community residents.
7. Develop and expand community-level partnerships among local schools, police, parks and public works departments, community and civic-based organizations, businesses, and political leaders to create and maintain community environments that are supportive of physical activity, such as walking, jogging, and bicycling.

APPENDIX

RELEVANT *HEALTHY PEOPLE 2010* OBJECTIVES FOR TARGETED FOCUS AREAS

FOCUS AREA	OBJECTIVE		NATIONAL BASELINE
Workforce Diversity	1-8	In the health professions, allied and associated health profession fields, and the nursing field, increase the proportion of all degrees awarded to members of underrepresented racial and ethnic groups.	
	1-8a	In the health professions, allied and associated health profession fields, increase the proportion of all degrees awarded to American Indians or Alaska Natives from 0.6% (1996-97) to 1.0%.	• American Indian or Alaska Native: 0.6% • Asian or Pacific Islander: 16.2% • Black or African American: 6.7% • Hispanic or Latino: 4.0%
	1-8b	In the health professions, allied and associated health profession fields, increase the proportion of all degrees awarded to Asians or Pacific Islanders from 16.2% (1996-97) to 4.0% (*exceeds target based on estimated population*).	• American Indian or Alaska Native: 0.6% • Asian or Pacific Islander: 16.2% • Black or African American: 6.7% • Hispanic or Latino: 4.0%
	1-8c	In the health professions, allied and associated health profession fields, increase the proportion of all degrees awarded to Blacks or African Americans from 6.7% (1996-97) to 13.0%.	• American Indian or Alaska Native: 0.6% • Asian or Pacific Islander: 16.2% • Black or African American: 6.7% • Hispanic or Latino: 4.0%
	1-8d	In the health professions, allied and associated health profession fields, increase the proportion of all degrees awarded to Hispanics or Latinos from 4.0% (1996-97) to 12.0%.	• American Indian or Alaska Native: 0.6% • Asian or Pacific Islander: 16.2% • Black or African American: 6.7% • Hispanic or Latino: 4.0%
	1-8e	In the nursing field, increase the proportion of all degrees awarded to American Indians or Alaska Natives from 0.7% (1995-96) to 1.0%.	• American Indian or Alaska Native: 0.7% • Asian or Pacific Islander: 3.2% • Black or African American: 6.9% • Hispanic or Latino: 3.4%
	1-8f	In the nursing field, increase the	• American Indian or Alaska Native:

		proportion of all degrees awarded to Asians or Pacific Islanders from 3.2% (1995-96) to 4.0%.	0.7% • Asian or Pacific Islander: 3.2% • Black or African American: 6.9% • Hispanic or Latino: 3.4%
	1-8g	In the nursing field, increase the proportion of all degrees awarded to Blacks or African Americans from 6.9% (1995-96) to 13.0%.	• American Indian or Alaska Native: 0.7% • Asian or Pacific Islander: 3.2% • Black or African American: 6.9% • Hispanic or Latino: 3.4%
	1-8h	In the nursing field, increase the proportion of all degrees awarded to Hispanics or Latinos from 3.4% (1995-96) to 12.0%.	• American Indian or Alaska Native: 0.7% • Asian or Pacific Islander: 3.2% • Black or African American: 6.9% • Hispanic or Latino: 3.4%
	1-8i	In medicine, increase the proportion of all degrees awarded to American Indians or Alaska Natives from 0.6% (1996-97) to 1.0%.	• American Indian or Alaska Native: 0.6% • Asian or Pacific Islander: 15.9% • Black or African American: 7.3% • Hispanic or Latino: 4.6%
	1-8j	In medicine, increase the proportion of all degrees awarded to Asians or Pacific Islanders from 15.9% (1996-97) to 4.0% (exceeds target based on estimated population).	• American Indian or Alaska Native: 0.6% • Asian or Pacific Islander: 15.9% • Black or African American: 7.3% • Hispanic or Latino: 4.6%
	1-8k	In medicine, increase the proportion of all degrees awarded to Blacks or African Americans from 7.3% (1996-97) to 13.0%.	• American Indian or Alaska Native: 0.6% • Asian or Pacific Islander: 15.9% • Black or African American: 7.3% • Hispanic or Latino: 4.6%
	1-8l	In medicine, increase the proportion of all degrees awarded to Hispanics or Latinos from 4.6% (1996-97) to 12.0%.	• American Indian or Alaska Native: 0.6% • Asian or Pacific Islander: 15.9% • Black or African American: 7.3% • Hispanic or Latino: 4.6%
	1-8m	In dentistry, increase the proportion of all degrees awarded to American Indians or Alaska Natives from 0.5% (1996-97) to 1.0%.	• American Indian or Alaska Native: 0.5% • Asian or Pacific Islander: 19.5% • Black or African American: 5.1% • Hispanic or Latino: 4.7%
	1-8n	In dentistry, increase the proportion of all	• American Indian or Alaska Native:

		degrees awarded to Asians or Pacific Islanders from 19.5% (1996-97) to 4.0% (*exceeds target based on estimated population*).	0.5% • Asian or Pacific Islander: 19.5% • Black or African American: 5.1% • Hispanic or Latino: 4.7%
	1-8o	In dentistry, increase the proportion of all degrees awarded to Blacks or African Americans from 5.1% (1996-97) to 13.0%.	• American Indian or Alaska Native: 0.5% • Asian or Pacific Islander: 19.5% • Black or African American: 5.1% • Hispanic or Latino: 4.7%
	1-8p	In dentistry, increase the proportion of all degrees awarded to Hispanics or Latinos from 4.7% (1996-97) to 12.0%.	• American Indian or Alaska Native: 0.5% • Asian or Pacific Islander: 19.5% • Black or African American: 5.1% • Hispanic or Latino: 4.7%
	1-8q	In pharmacy, increase the proportion of all degrees awarded to American Indians or Alaska Natives from 0.4% (1996-97) to 1.0%.	• American Indian or Alaska Native: 0.4% • Asian or Pacific Islander: 17.5% • Black or African American: 5.7% • Hispanic or Latino: 2.8%
	1-8r	In pharmacy, increase the proportion of all degrees awarded to Asians or Pacific Islanders from 17.5% (1996-97) to 4.0% (*exceeds target based on estimated population*).	• American Indian or Alaska Native: 0.4% • Asian or Pacific Islander: 17.5% • Black or African American: 5.7% • Hispanic or Latino: 2.8%
	1-8s	In pharmacy, increase the proportion of all degrees awarded to Blacks or African Americans from 5.7% (1996-97) to 13.0%.	• American Indian or Alaska Native: 0.4% • Asian or Pacific Islander: 17.5% • Black or African American: 5.7% • Hispanic or Latino: 2.8%
	1-8t	In pharmacy, increase the proportion of all degrees awarded to Hispanics or Latinos from 2.8% (1996-97) to 12.0%.	• American Indian or Alaska Native: 0.4% • Asian or Pacific Islander: 17.5% • Black or African American: 5.7% • Hispanic or Latino: 2.8%
Cultural and Linguistic Competence	11-2	Improve the health literacy of persons with inadequate or marginal literacy skills.	
	11-6	Increase the proportion of persons who report that their health care providers have satisfactory communication skills.	

Heart Disease	12-1	Reduce coronary heart disease deaths from 208 coronary heart disease deaths per 100,000 (1998) to 166 deaths per 100,000 population (20% improvement).	• Total: 216 per 100,000 (1997) • American Indian or Alaska Native: 134 per 100,000 • Asian or Pacific Islander: 125 per 100,000 • Black or African American: 257 per 100,000 • Hispanic or Latino: 151 per 100,000 • White: 214 per 100,000
	12-2	Increase the proportion of adults aged 20 years and older who are aware of the early warning symptoms and signs of a heart attack and the importance of accessing rapid emergency care by calling 911.	
	12-4	Increase the proportion of adults aged 20 years and older who call 911 and administer cardiopulmonary resuscitation (CPR) when they witness an out-or-hospital cardiac arrest.	
	12-5	Increase the proportion of persons with witnessed out-or-hospital cardiac arrest who are eligible and receive their first therapeutic electrical shock within 6 minutes after collapse recognition.	
	12-9	Reduce the proportion of adults with high blood pressure from 28% of adults aged 20 years and older (1998-94) to 16%.	• Total: 28% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 40% • Hispanic or Latino: Data are not collected • White: 27%
	12-10	Increase the proportion of adults with high blood pressure whose blood pressure is under control from 18% of adults aged 18 years and older with high blood pressure (1988-94) to 50%.	• Total: 18% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 19% • Hispanic or Latino: Data are not collected • White: 18%
	12-11	Increase the proportion of adults with high blood pressure who are taking action	• Total: 79% (1994) • American Indian or Alaska Native:

		(for example, losing weight, increasing physical activity, and reducing sodium intake) to help control their blood pressure from 72% of adults aged 18 years and older with high blood pressure (1998) to 95%.	Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 84% • Hispanic or Latino: 79% • White: 78%
	12-12	Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high from 90% of adults aged 18 years and older (1998) to 95%.	• Total: 85% (1994) • American Indian or Alaska Native: 85% • Asian or Pacific Islander: 80% • Black or African American: 88% • Hispanic or Latino: 80% • White: 85%
	12-13	Reduce the mean total blood cholesterol levels among adults from 206 mg/dL for adults aged 20 years and older (1988-94) to 199 mg/dL.	• Total: 206 mg/dL • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 204 mg/dL • Hispanic or Latino: Data are not collected • White: 206 mg/dL
	12-14	Reduce the proportion of adults with high total blood cholesterol levels from 21% of adults aged 20 years and older (1988-94) to 17%.	• Total: 21% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 19% • Hispanic or Latino: Data are not collected • White: 21%
	12-15	Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years from 68% of adults aged 18 years and older (1998) to 80%.	• Total: 67% (1993) • American Indian or Alaska Native: 57% • Asian or Pacific Islander: 58% • Black or African American: 66% • Hispanic or Latino: 62% • White: 67%
Cancer	3-1	Reduce the overall cancer death rate from 201.4 cancer deaths per 100,000 population (1998) to 158.7 cancer deaths per 100,000 population (21% improvement).	• Total: 205.7 per 100,000 • American Indian or Alaska Native: 131.8 per 100,000 • Asian or Pacific Islander: 127.2 per 100,000 • Black or African American: 262.1

			per 100,000 • Hispanic or Latino: 125.5 per 100,000 • White: 202.2 per 100,000
	3-2	Reduce the lung cancer death rate from 57.4 lung cancer deaths per 100,000 population (1998) to 44.8 deaths per 100,000 population (22% improvement).	• Total: 58.1 per 100,000 • American Indian or Alaska Native: 36.3 per 100,000 • Asian or Pacific Islander: 28.9 per 100,000 • Black or African American: 67.9 per 100,000 • Hispanic or Latino: 23.9 per 100,000 • White: 58.0 per 100,000
	3-3	Reduce the death rate from breast cancer from 27.9 breast cancer deaths per 100,000 females (1998) to 22.3 deaths per 100,000 females (20% improvement).	• Total: 27.9 per 100,00 • American Indian or Alaska Native: 14.2 per 100,000 • Asian or Pacific Islander: 13.1 per 100,000 • Black or African American: 35.7 per 100,000 • Hispanic or Latino: 16.8 per 100,000 • White: 27.3 per 100,000
	3-4	Reduce the death rate from cancer of the uterine cervix from 3.0 cervical cancer deaths per 100,000 females (1998) to 2.0 deaths per 100,000 females (33% improvement).	• Total: 3.2 per 100,000 • American Indian or Alaska Native: 4.0 per 100,000 • Asian or Pacific Islander: 3.0 per 100,000 • Black or African American: 6.5 per 100,000 • Hispanic or Latino: 3.8 per 100,000 • White: 2.8 per 100,000
	3-5	Reduce the colorectal cancer death rate from 21.1 colorectal cancer deaths per 100,000 population (1998) to 13.9 deaths per 100,000 population (34% improvement).	• Total: 21.6 per 100,000 • American Indian or Alaska Native: 14.5 per 100,000 • Asian or Pacific Islander: 13.5 per 100,000 • Black or African American: 28.8 per 100,000 • Hispanic or Latino: 12.8 per 100,000 • White: 21.1 per 100,000
	3-6	Reduce the oropharyngeal cancer death rate from 2.9 oropharyngeal cancer deaths per 100,000 population (1998) to 2.6 deaths per 100,000 population (10% improvement).	• Total: 3.0 per 100,000 • American Indian or Alaska Native: 2.6 per 100,000 • Asian or Pacific Islander: 2.5 per 100,000

			• Black or African American: 4.7 per 100,000 • Hispanic or Latino: 1.8 per 100,000 • White: 2.8 per 100,000
	3-7	Reduce the prostate cancer death rate from 31.9 prostate cancer deaths per 100,000 males (1998) to 28.7 deaths per 100,000 males (10% improvement).	• Total: 33.8 per 100,000 • American Indian or Alaska Native: 19.3 per 100,000 • Asian or Pacific Islander: 14.5 per 100,000 • Black or African American: 71.1 per 100,000 • Hispanic or Latino: 20.8 per 100,000 • White: 31.1 per 100,000
	3-10	Increase the proportion of physicians and dentists who counsel their at-risk patients about tobacco use cessation, physical activity, and cancer screening from 22-59% (1998) to 85%.	
	3-11	Increase the proportion of women who receive a Pap test from 92% (1998) to 97% for women aged 18 years and older who have ever received a Pap test and from 79% (1998) to 90% for women aged 18 years and older who received a Pap test within the preceding 3 years.	• Total: 94% ever – 77% in past 3 years • American Indian or Alaska Native: 93% ever – 68% in past 3 years • Asian or Pacific Islander: 82% ever – 63% in past 3 years • Black or African American: 96% ever – 81% in past 3 years • Hispanic or Latino: 91% ever – 71% in past 3 years • White: 95% ever – 77% in past 3 years
	3-12	Increase the proportion of adults who receive a colorectal cancer screening examination from 34% (1998) to 50% for adults aged 50 years and older who have received a fecal occult blood test (FOBT) within the preceding 2 years and from 38% (1998) to 50% for adults aged 50 years and older who have ever received sigmoidoscopy.	• Total: 30% fecal occult blood test – 33% sigmoidoscopy • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 25% fecal occult blood test – 27% sigmoidoscopy • Hispanic or Latino: 22% fecal occult blood test – 28% sigmoidoscopy • White: 30% fecal occult blood test – 34% sigmoidoscopy
	3-13	Increase the proportion of women aged 40 years and older who have received a mammogram within the preceding 2 years	• Total: 59% • American Indian or Alaska Native: Data are statistically unreliable

		from 68% (1998) to 70%.	• Asian or Pacific Islander: 49% • Black or African American: 61% • Hispanic or Latino: 51% • White: 59%
	3-14	Increase the number of states that have a statewide population-based cancer registry that captures case information on at least 95% of the expected number of reportable cancers from 21 states (1999) to 45 states (114% improvement).	
	3-15	Increase the proportion of cancer survivors who are living 5 years or longer after diagnosis from 59% (1989-95) to 70% (19% improvement).	• Total: 59% • American Indian or Alaska Native: Data have not been analyzed • Asian or Pacific Islander: Data have not been analyzed • Black or African American: 48% • Hispanic or Latino: Data have not been analyzed • White: 61%
Stroke	12-7	Reduce stroke deaths from 60 deaths from stroke per 100,000 (1998) to 48 deaths per 100,000 population (20% improvement).	• Total: 62 per 100,000 (1997) • American Indian or Alaska Native: 39 per 100,000 • Asian or Pacific Islander: 55 per 100,000 • Black or African American: 82 per 100,000 • Hispanic or Latino: 40 per 100,000 • White: 60 per 100,000
	12-8	Increase the proportion of adults who are aware of the early warning symptoms and signs of a stroke.	
	12-9	Reduce the proportion of adults with high blood pressure from 28% of adults aged 20 years and older (1998-94) to 16%.	• Total: 28% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 40% • Hispanic or Latino: Data are not collected • White: 27%
	12-10	Increase the proportion of adults with high blood pressure whose blood pressure is under control from 18% of adults aged 18 years and older with high blood pressure (1988-94) to 50%.	• Total: 18% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable

			• Black or African American: 19% • Hispanic or Latino: Data are not collected • White: 18%
	12-11	Increase the proportion of adults with high blood pressure who are taking action (for example, losing weight, increasing physical activity, and reducing sodium intake) to help control their blood pressure from 72% of adults aged 18 years and older with high blood pressure (1998) to 95%.	• Total: 79% (1994) • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 84% • Hispanic or Latino: 79% • White: 78%
	12-12	Increase the proportion of adults who have had their blood pressure measured within the preceding 2 years and can state whether their blood pressure was normal or high from 90% of adults aged 18 years and older (1998) to 95%.	• Total: 85% (1994) • American Indian or Alaska Native: 85% • Asian or Pacific Islander: 80% • Black or African American: 88% • Hispanic or Latino: 80% • White: 85%
	12-13	Reduce the mean total blood cholesterol levels among adults from 206 mg/dL for adults aged 20 years and older (1988-94) to 199 mg/dL.	• Total: 206 mg/dL • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 204 mg/dL • Hispanic or Latino: Data are not collected • White: 206 mg/dL
	12-14	Reduce the proportion of adults with high total blood cholesterol levels from 21% of adults aged 20 years and older (1988-94) to 17%.	• Total: 21% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 19% • Hispanic or Latino: Data are not collected • White: 21%
	12-15	Increase the proportion of adults who have had their blood cholesterol checked within the preceding 5 years from 68% of adults aged 18 years and older (1998) to 80%.	• Total: 67% (1993) • American Indian or Alaska Native: 57% • Asian or Pacific Islander: 58% • Black or African American: 66% • Hispanic or Latino: 62% • White: 67%

Asthma	24-1	Reduce asthma deaths.	
	24-1a	Reduce asthma deaths for children under 5 years from 1.7 per 1,000,000 (1998) to 1.0 per 1,000,000.	• Total: 1.8 per 1,000,000 (1997) • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 7.6 per 1,000,000 • Hispanic or Latino: Data are statistically unreliable • White: Data are statistically unreliable
	24-1b	Reduce asthma deaths for children aged 5 to 14 years from 3.2 per 1,000,000 (1998) to 1.0 per 1,000,000.	• Total: 3.1 per 1,000,000 (1997) • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 9.7 per 1,000,000 • Hispanic or Latino: Data are statistically unreliable • White: 1.8 per 1,000,000
	24-1c	Reduce asthma deaths for adolescents and adults aged 15 to 34 years from 5.9 per 1,000,000 (1998) to 3.0 per 1,000,000.	• Total: 6.2 per 1,000,000 (1997) • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 17.4 per 1,000,000 • Hispanic or Latino: 4.8 per 1,000,000 • White: 4.3 per 1,000,000
	24-1d	Reduce asthma deaths for adults aged 35 to 64 years from 17.0 per 1,000,000 (1998) to 9.0 per 1,000,000.	• Total: 18.9 per 1,000,000 (1997) • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: 22.3 per 1,000,000 • Black or African American: 52.7 per 1,000,000 • Hispanic or Latino: 17.1 per 1,000,000 • White: 14.3 per 1,000,000
	24-1e	Reduce asthma deaths for adults aged 65 years and older from 87.5 per 1,000,000 (1998) to 60.0 per 1,000,000.	• Total: 85.9 per 1,000,000 (1997) • American Indian or Alaska Native: Data are statistically unreliable

			• Asian or Pacific Islander: 141.2 per 1,000,000 • Black or African American: 120.2 per 1,000,000 • Hispanic or Latino: 81.8 per 100,000 • White: 81.5 per 1,000,000
	24-2	Reduce hospitalizations for asthma.	
	24-2a	Reduce hospitalizations for asthma for children under 5 years from 60.9 per 10,000 (1997) to 25.0 per 10,000.	• Total: 60.9 per 10,000 • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 125.6 per 10,000 • Hispanic or Latino: Data are statistically unreliable • White: 33.3 per 10,000
	24-2b	Reduce hospitalizations for asthma for children and adults aged 5 to 64 years from 13.8 per 10,000 (1997) to 8.0 per 10,000.	• Total: 13.8 per 10,000 • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 26.4 per 10,000 • Hispanic or Latino: Data are statistically unreliable • White: 9.3 per 10,000
	24-2c	Reduce hospitalizations for asthma for adults aged 65 years and older from 19.3 per 10,000 (1997) to 10.0 per 10,000.	• Total: 19.3 per 10,000 • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 26.5 per 10,000 • Hispanic or Latino: Data are statistically unreliable • White: 15.4 per 10,000
	24-3	Reduce hospital emergency department visits for asthma.	
	24-3a	Reduce hospital emergency department visits for asthma for children under 5 years from 150.0 per 10,000 (1995-97) to 80.0 per 10,000.	• Total: 150.0 per 10,000 • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 407.2

			per 10,000 • Hispanic or Latino: Data are statistically unreliable • White: 101.7 per 10,000
	24-3b	Reduce hospital emergency department visits for asthma for children and adults aged 5 to 64 years from 71.1 per 10,000 (1995-97) to 50.0 per 10,000.	• Total: 71.1 per 10,000 • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 191.7 per 10,000 • Hispanic or Latino: Data are statistically unreliable • White: 53.4 per 10,000
	24-3c	Reduce hospital emergency department visits for asthma for adults aged 65 years and older from 29.5 per 10,000 (1995-97) to 15.0 per 10,000.	• Total: 29.5 per 10,000 • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 90.8 per 10,000 • Hispanic or Latino: Data are statistically unreliable • White: 23.1 per 10,000
	24-4	Reduce activity limitations among persons with asthma from 19.5% of persons with asthma (1994-96) to 10.0%.	• Total: 19.5% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 26.3% • Hispanic or Latino: 22.4% • White: 18.3%
	24-5	Reduce the number of school or work days missed by persons with asthma due to asthma.	Developmental HP2010 Objective (data not available nationally)
	24-6	Increase the proportion of persons with asthma who receive formal patient education, including information about community and self-help resources, as an essential part of the management of their condition from 6.4% (1998) to 30%.	• Total: 10.0% (1993) • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: Data are statistically unreliable • Hispanic or Latino: Data are statistically unreliable • White: 10.0%

	24-7	Increase the proportion of persons with asthma who receive appropriate asthma care according to the National Asthma Education and Prevention Program (NAEPP) Guidelines.	
	24-7a	Persons with asthma who receive written asthma management plans from their health care provider.	
	24-7b	Persons with asthma with prescribed inhalers who receive instruction on how to use them properly.	
	24-7c	Persons with asthma who receive education about recognizing early signs and symptoms of asthma episodes and how to respond appropriately, including instruction on peak flow monitoring for those who use daily therapy.	
	24-7d	Persons with asthma who receive medication regimens that prevent the need for more than one canister of short acting inhaled beta agonists per month for relief of symptoms.	
	24-7e	Persons with asthma who receive follow-up medical care for long-term management of asthma after any hospitalization due to asthma.	
	24-7f	Persons with asthma who receive assistance with assessing and reducing exposure to environmental risk factors in their home, school, and work environments.	
	24-8	Establish in at least 15 states a surveillance system for tracking asthma death, illness, disability, impact of occupational and environmental factors on asthma, access to medical care, and asthma management.	
Diabetes	5-1	Increase the proportion of persons with diabetes who receive formal diabetes education from 40% (1998) to 60%.	• Total: 45% (1993) • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 55% • Hispanic or Latino: Data are statistically unreliable • White: 42%

	5-2	Prevent diabetes from 3.1 new cases of diabetes per 1,000 persons per year (1994-96) to 2.5 new cases per 1,000 persons per year.	• Total: 3.1 per 1,000 • American Indian or Alaska Native: 8.7 per 1,000 • Asian or Pacific Islander: 2.9 per 1,000 • Black or African American: 3.7 per 1,000 • Hispanic or Latino: 3.5 per 1,000 • White: 3.0 per 1,000
	5-3	Reduce the overall rate of diabetes that is clinically diagnosed from 40 overall cases (new and existing) of diabetes per 1,000 population (1997) to 25 overall cases per 1,000 population.	• Total: 40 per 1,000 • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable • Black or African American: 74 per 1,000 • Hispanic or Latino: 61 per 1,000 • White: 36 per 1,000
	5-5	Reduce the diabetes death rate from 75 deaths per 100,000 persons (1997) to 45 deaths per 100,000 persons (43% improvement).	• Total: 75 per 100,000 • American Indian or Alaska Native: 107 per 100,000 • Asian or Pacific Islander: 62 per 100,000 • Black or African American: 130 per 100,000 • Hispanic or Latino: 86 per 100,000 • White: 70 per 100,000
	5-12	Increase the proportion of adults with diabetes who have a glycosylated hemoglobin measurement at least once a year from 24% of adults aged 18 years and older with diabetes (1998) to 50%.	• Total: 24% • American Indian or Alaska Native: 29% • Asian or Pacific Islander: 48% • Black or African American: 21% • Hispanic or Latino: 22% • White: 25%
	5-13	Increase the proportion of adults with diabetes who have an annual dilated eye examination from 56% of adults aged 18 years and older with diabetes (1998) to 75%.	• Total: 56% • American Indian or Alaska Native: 60% • Asian or Pacific Islander: 69% • Black or African American: 59% • Hispanic or Latino: 53% • White: 55%
	5-14	Increase the proportion of adults with diabetes who have at least an annual foot	• Total: 55% • American Indian or Alaska Native:

		examination from 55% of adults aged 18 years and older with diabetes (1998) to 75%.	40% • Asian or Pacific Islander: 57% • Black or African American: 55% • Hispanic or Latino: 56% • White: 55%
	5-15	Increase the proportion of persons with diabetes who have at least an annual dental examination from 58% of persons aged 2 years and older with diabetes (1997) to 75%.	• Total: 58% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: 56% • Black or African American: 63% • Hispanic or Latino: 32% • White: 58%
	5-17	Increase the proportion of adults with diabetes who perform self-blood glucose monitoring at least once daily from 42% of adults aged 18 years and older with diabetes (1998) to 60%.	• Total: 42% • American Indian or Alaska Native: 53% • Asian or Pacific Islander: 30% • Black or African American: 40% • Hispanic or Latino: 36% • White: 43%
HIV/AIDS	13-1	Reduce AIDS among adolescents and adults from 19.5 cases of AIDS per 100,000 persons aged 13 years and older (1988) to 1.0 new case per 100,000.	• Total: 19.5 per 100,000 • American Indian or Alaska Native: 9.4 per 100,000 • Asian or Pacific Islander: 4.3 per 100,000 • Black or African American: 82.9 per 100,000 • Hispanic or Latino: 33.0 per 100,000 • White: 8.5 per 100,000
	13-2	Reduce the number of new AIDS cases among adolescent and adult men who have sex with men from 17,847 new cases among males aged 13 years and older (1998) to 13,385 new cases (25% improvement).	
	13-3	Reduce the number of new AIDS cases among females and males who inject drugs from 12,099 new cases of AIDS among injection drug users aged 13 years and older (1998) to 9,075 new cases (25% improvement).	
	13-6	Increase the proportion of sexually active persons who use condoms from 23% of unmarried females aged 18 to 44 years to 50% (data on males aged 18 to 49 years will be collected and reported by 2003).	• Total: 23% • American Indian or Alaska Native: Data are statistically unreliable • Asian or Pacific Islander: Data are statistically unreliable

			• Black or African American: 22% • Hispanic or Latino: 17% • White: 23%
	13-13	Increase the proportion of HIV-infected adolescents and adults who receive testing, treatment, and prophylaxis consistent with current Public Health Service treatment guidelines from 43-95% (1997) to 95%.	
	13-14	Reduce deaths from HIV infection from 4.9 deaths from HIV infection per 100,000 persons (1998) to 0.8 death per 100,000 persons.	• Total: 6.1 per 100,000 (1997) • American Indian or Alaska Native: 2.5 per 100,000 • Asian or Pacific Islander: 0.9 per 100,000 • Black or African American: 26.6 per 100,000 • Hispanic or Latino: 8.9 per 100,000 • White: 3.5 per 100,000
Infant Mortality	16-1	Reduce fetal and infant deaths.	
	16-1a	Reduce fetal and infant deaths at 20 or more weeks of gestation from 6.8 per 1,000 live births plus fetal deaths (1997) to 4.1 per 1,000 live births plus fetal deaths.	• Total: 6.8 per 1,000 • American Indian or Alaska Native: 6.7 per 1,000 • Asian or Pacific Islander: 4.8 per 1,000 • Black or African American: 12.5 per 1,000 • Hispanic or Latino: 5.9 per 1,000 • White: 5.8 per 1,000
	16-1b	Reduce fetal and infant deaths during perinatal period (28 weeks of gestation to 7 days or more after birth) from 7.5 per 1,000 live births plus fetal deaths (1997) to 4.5 per 1,000 live births plus fetal deaths.	• Total: 7.5 per 1,000 • American Indian or Alaska Native: 7.9 per 1,000 • Asian or Pacific Islander: 4.6 per 1,000 • Black or African American: 13.4 per 1,000 • Hispanic or Latino: 6.5 per 1,000 • White: 6.4 per 1,000
	16-1c	Reduce all infant deaths (within 1 year) from 7.2 per 1,000 live births (1998) to 4.5 per 1,000 live births.	• Total: 7.2 per 1,000 • American Indian or Alaska Native: 9.3 per 1,000 • Asian or Pacific Islander: 5.5 per 1,000 • Black or African American: 13.8 per 1,000 • Hispanic or Latino: 5.8 per 1,000

			• White: 6.0 per 1,000
	16-1d	Reduce neonatal deaths (within the first 28 days of life) from 4.8 per 1,000 live births (1998) to 2.9 per 1,000 live births.	• Total: 4.8 per 1,000 • American Indian or Alaska Native: 5.0 per 1,000 • Asian or Pacific Islander: 3.9 per 1,000 • Black or African American: 9.4 per 1,000 • Hispanic or Latino: 3.9 per 1,000 • White: 4.0 per 1,000
	16-1e	Reduce post-neonatal deaths (between 28 days and 1 year) from 2.4 per 1,000 live births (1998) to 1.2 per 1,000 live births.	• Total: 2.4 per 1,000 • American Indian or Alaska Native: 4.3 per 1,000 • Asian or Pacific Islander: 1.7 per 1,000 • Black or African American: 4.4 per 1,000 • Hispanic or Latino: 1.9 per 1,000 • White: 2.0 per 1,000
	16-1h	Reduce deaths from sudden infant death syndrome (SIDS) from 0.72 deaths per 1,000 live births (1998) to 0.25 deaths per 1,000 live births.	• Total: 0.72 per 1,000 • American Indian or Alaska Native: 1.52 per 1,000 • Asian or Pacific Islander: 0.39 per 1,000 • Black or African American: 1.38 per 1,000 • Hispanic or Latino: 0.37 per 1,000 • White: 0.60 per 1,000
	16-6	Increase the proportion of pregnant women who receive early and adequate prenatal care.	
	16-6a	Increase the proportion of pregnant women who receive prenatal care beginning in first trimester of pregnancy from 83% of live births (1998) to 90% of live births.	• Total: 83% • American Indian or Alaska Native: 69% • Asian or Pacific Islander: 83% • Black or African American: 73% • Hispanic or Latino: 74% • White: 85%
	16-6b	Increase the proportion of pregnant women who receive early and adequate prenatal care from 74% of live births (1997) to 90% of live births.	• Total: 74% • American Indian or Alaska Native: 57% • Asian or Pacific Islander: 74% • Black or African American: 67% • Hispanic or Latino: 66%

			• White: 76%
	16-10	Reduce low birth weight (LBW) and very low birth weight (VLBW).	
	16-10a	Reduce low birth weight (LBW) from 7.6% (1998) to 5.0%.	• Total: 7.6% • American Indian or Alaska Native: 6.8% • Asian or Pacific Islander: 7.4% • Black or African American: 13.0% • Hispanic or Latino: 6.4% • White: 6.5%
	16-10b	Reduce very low birth weight (VLBW) from 1.4% (1998) to 0.9%.	• Total: 1.4% • American Indian or Alaska Native: 1.2% • Asian or Pacific Islander: 1.1% • Black or African American: 3.1% • Hispanic or Latino: 1.1% • White: 1.1%
	16-11	Reduce pre-term births.	
	16-11a	Reduce total pre-term births from 11.6% (1998) to 7.6%.	• Total: 11.6% • American Indian or Alaska Native: 12.2% • Asian or Pacific Islander: 10.4% • Black or African American: 17.5% • Hispanic or Latino: 11.4% • White: 10.5%
	16-11b	Reduce live births at 32 to 36 weeks of gestation from 9.6% (1998) to 6.4%.	• Total: 9.6% • American Indian or Alaska Native: 10.2% • Asian or Pacific Islander: 8.9% • Black or African American: 13.4% • Hispanic or Latino: 9.7% • White: 8.9%
	16-11c	Reduce live births at less than 32 weeks of gestation from 2.0% (1998) to 1.1%.	• Total: 2.0% • American Indian or Alaska Native: 2.0% • Asian or Pacific Islander: 1.4% • Black or African American: 4.1% • Hispanic or Latino: 1.7% • White: 1.6%
	16-17	Increase abstinence from alcohol, cigarettes, and illicit drugs among	

		pregnant women.	
	16-17a	Increase abstinence from alcohol among pregnant women from 86% of pregnant women (1996-97) to 94%.	• Total: 86% • American Indian or Alaska Native: Data have not been analyzed • Asian or Pacific Islander: Data have not been analyzed • Black or African American: Data have not been analyzed • Hispanic or Latino: 93% • White: Data have not been analyzed
	16-17c	Increase abstinence from cigarette smoking among pregnant women from 87% of pregnant women (1998) to 99%.	• Total: 87% • American Indian or Alaska Native: 80% • Asian or Pacific Islander: 97% • Black or African American: 91% • Hispanic or Latino: 96% • White: 86%
	16-17d	Increase abstinence from illicit drugs among pregnant women from 98% of pregnant women (1996-97) to 100%.	• Total: 98% • American Indian or Alaska Native: Data have not been analyzed • Asian or Pacific Islander: Data have not been analyzed • Black or African American: Data have not been analyzed • Hispanic or Latino: 99% • White: Data have not been analyzed

SUMMARY TABLE

FOCUS AREA	HP2010	HIMH2010	ACTIONS AND INTERVENTIONS
Workforce Diversity	1-8		
	1-8a	WFD-1	WFD-S1.1 – S1.6
		WFD-6	WFD-S6.1 – S6.6
		WFD-7	WFD-S7.1 – S7.6
	1-8b	WFD-1	WFD-S1.1 – S1.6
		WFD-6	WFD-S6.1 – S6.6
		WFD-7	WFD-S7.1 – S7.6
	1-8c	WFD-1	WFD-S1.1 – S1.6
		WFD-6	WFD-S6.1 – S6.6
		WFD-7	WFD-S7.1 – S7.6
	1-8d	WFD-1	WFD-S1.1 – S1.6
		WFD-6	WFD-S6.1 – S6.6
		WFD-7	WFD-S7.1 – S7.6
	1-8e	WFD-2	WFD-S2.1 – S2.6
	1-8f	WFD-2	WFD-S2.1 – S2.6
	1-8g	WFD-2	WFD-S2.1 – S2.6
	1-8h	WFD-2	WFD-S2.1 – S2.6
	1-8i	WFD-3	WFD-S3.1 – S3.6
	1-8j	WFD-3	WFD-S3.1 – S3.6
	1-8k	WFD-3	WFD-S3.1 – S3.6
	1-8l	WFD-3	WFD-S3.1 – S3.6
	1-8m	WFD-4	WFD-S4.1 – S4.6
	1-8n	WFD-4	WFD-S4.1 – S4.6
	1-8o	WFD-4	WFD-S4.1 – S4.6
	1-8p	WFD-4	WFD-S4.1 – S4.6
	1-8q	WFD-5	WFD-S5.1 – S5.6
	1-8r	WFD-5	WFD-S5.1 – S5.6
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Cultural and Linguistic Competence	11-2		
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		CLC-3	CLC-S3.1 – S3.3
		CLC-4	CLC-S4.1
		CLC-5	CLC-S5.1 – S5.2
		CLC-6	CLC-S6.1 – S6.2
		CLC-7	CLC-S7.1 – S7.2
		CLC-8	CLC-S8.1 – S8.3
		CLC-9	CLC-S9.1 – S9.2
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		CVD-2	CVD-S2.1 – S2.3
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	12-5	CVD-S1.3 – S2.3	
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		CVD-5	CVD-S5.1 – S5.2
	12-15	CVD-6	CVD-S6.1 – S6.2
		CVD-7	CVD-S7.1 – S7.2

	12-10	CVD-U1	CVD-S3.1 – S3.10
	12-11	CVD-U2	
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		CAN-3	CAN-S3.1 – S3.6
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	3-4	CAN-6	CAN-S6.1 – S6.8
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	12-14	STR-4	STR –S4.1 – S4.2
		STR-5	STR –S5.1 – S5.2
	12-15	STR-6	STR –S6.1 – S6.2
		STR-7	STR –S7.1 – S7.2
	12-10	STR-U1	STR –S3.1 – S3.10
	12-11	STR-U2	
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	12-13	STR-U4	STR –S4.1 – S7.1
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	24-1c	AST-U2	AST-S2.7
			AST-SU2.1 – SU2.6
	24-1d	AST-U3	AST-S2.7
			AST-SU3.1 – SU3.6
	24-1e	AST-U4	AST-S2.7
			AST-SU4.1 – SU4.6
	24-2		
	24-2a	AST-U5	AST-S2.6
			AST-SU1.1 – SU4.1
			AST-SU1.2 – SU4.2
	24-2b	AST-U6	AST-S2.6
			AST-SU1.1 – SU4.1
			AST-SU1.2 – SU4.2
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			AST-SU1.2 – SU4.2
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			AST-SU8.1 – SU11.1
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		DIA-3	DIA-S3.1 – S3.13
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	5-2	DIA-U2	DIA-S1.1 – S1.13
			DIA-S2.1 – S2.13
			DIA-S3.1 – S3.13
	5-12	DIA-U3	DIA-SU3.1
	5-13	DIA-U4	
			DIA-SU4.1 – SU4.2
	5-14	DIA-U5	DIA-SU3.1
			DIA-SU4.1
	5-15	DIA-U6	
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		HIV-3	HIV-S3.1 – S3.6
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HEALTHY PEOPLE 2010 OBJECTIVES
HEALTHY INDIANA MINORITY HEALTH 2010 OBJECTIVES
STRATEGIES AND ACTION
PROPOSED PLAN